The Cosmetic & Reconstructive Support Program (CRS™) of NCADV was created to connect survivors of domestic violence to medical associations and professionals. Assistance is available for those who need medical treatment or services to repair injuries inflicted by an abusive spouse or intimate partner. Currently, NCADV assists survivors with the application process to two medical programs, FACE TO FACE and Reconstructing Hope. We also refer those in need of different services to other entities, associations, and organizations.

APPLICANTS MUST MEET ALL THE FOLLOWING GUIDELINES TO QUALIFY FOR MEDICAL SERVICES:

The applicant must have received the physical injuries from an abusive intimate partner or spouse. For example: husband, wife, partner, boyfriend, girlfriend, someone the applicant dated or with whom has a child. Other situations, while traumatic, do not qualify. If the injury was caused by child abuse, elder abuse (if not a former romantic partner), sibling abuse, caregiver abuse, parent abuse, violent attacks, stranger assault, or accidental injury not related to domestic violence, the application will be denied.

The applicant must have been out of the relationship for at least one year. However, it does not matter how long ago the applicant received the injury. If the applicant has not been out of the relationship for at least one year, the application will be returned to the applicant who can reapply once the year requirement is met. An exception for a shorter time can be given if the abuser is deceased or in prison. If you have not been out of the relationship for at least one year, please wait to apply after that date.

All applicants must have had contact with a domestic violence advocate, social worker, counselor or therapist a minimum of one time.

This application will be returned if Page 4 is not completed properly. The applicant may contact the National Domestic Violence Hotline at 1-800-799-7233 to get the phone number of the nearest domestic violence agency or visit www.domesticshelters.org to find their nearest local program.

If you need someone to help you fill out this application, please check one of the following:

Si necesita la ayuda de alguien para llenar la solicitud, verifique marcando uno de los siguientes:

☐ English is not my native language and I need a translator.
Mi idioma nativo no es el inglés y necesito un/una traductor/a.

☐ Physical or literacy challenges make it difficult to fill out the application alone.
Desafíos de analfabetismo y/o problemas físicos me hacen difícil llenar la solicitud sola.

Name of person helping: ____________________________________________ Phone: ( ) _____-_______
Nombre de la persona que le ayudó a llenar la solicitud Número de teléfono

The information in this application is strictly confidential and will not be released without your consent; however, the media frequently asks for names of applicants so they can follow their progress. Please sign below ONLY if you are willing to interact with media. Leave this section blank if you are not interested.

Signature: ________________________________ Date: ____________________

NCADV CRS Application -1-
PLEASE FILL OUT ALL SECTIONS COMPLETELY AS DIRECTED

Please use blue or black ballpoint pen only to fill out this application. PRINT neatly and answer all questions completely. Incomplete or improperly completed applications will be returned.

Name: ____________________________________________

Mailing Address: ____________________________________________

City: ______________________ State: ______ Zip Code: ____________

Home Phone: ( ) ______ - _______ Other Phone: ( ) ______ - _______

Email Address (optional): ____________________________

If you change your address or phone number, notify NCADV as soon as possible. Your standing in the program could be jeopardized if we cannot contact you. If you do not have a safe phone number, please provide a phone number where we can leave a message.

• Did an intimate partner of spouse inflict the physical injuries upon you? (circle one) YES NO
  If NO, please explain they services you may need ____________________________

• Please list the month and year of separation from your abuser: MONTH: ______________ YEAR: ______
  If less than one year from today’s date, check one: □ abuser is deceased
  □ abuser is imprisoned
  □ other: ____________________________

• Are you able to pay for any of the consultation or procedures? (circle one) YES NO
  If YES, explain: ____________________________

• For funding purposes, we must demonstrate the level of family income for referred patients. Please indicate your family income level (check one):
  □ Less than $20,000 □ $40,000 to $45,000
  □ $20,000 to $25,000 □ $45,000 to $50,000
  □ $25,000 to $30,000 □ $50,000 to $55,000
  □ $35,000 to $40,000 □ More than $55,000

• Have you had prior cosmetic or reconstructive surgery? (circle one) YES NO
  If YES, explain: ____________________________

• Do you need cosmetic dentistry on your teeth? (circle one) YES NO

• Do you need laser tattoo removal surgery? (circle one) YES NO

• Do you need reconstructive surgery? (circle one) YES NO
  If YES, explain: ____________________________

• Do you need different medical attention? (circle one) YES NO
  If YES, explain: ____________________________
(Optional) Please fill out the following ONLY if reports were made. **DO NOT** send any additional documents as they will be discarded.

Police Reports (approximate date/place/description):

_________________________________________________________________________________

_________________________________________________________________________________

Medical Reports (approximate date/place/description):

_________________________________________________________________________________

_________________________________________________________________________________

Protection Order(s) (approximate date/place/description):

_________________________________________________________________________________

_________________________________________________________________________________

Please describe your scars and injuries. Give the dates they occurred. **DO NOT** send any additional documents or photos as they will be discarded.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

THIS APPLICATION WILL BE RETURNED TO YOU IF THE FOLLOWING SECTION IS NOT COMPLETED

All applicants for the FACE-TO-FACE program must see a counselor, advocate, social worker, therapist, or minister at least one time before the application is completed. There are two reasons for this requirement:

- To connect the applicant with local support systems within their community
- To have an independent source confirm that after having heard the applicant’s story in at least one in-person interview, they believe the applicant received their injuries from an intimate partner or spouse and that the applicant is now out of the abusive relationship.

The applicant may either see someone they have talked with in the past or seek a referral to a local domestic violence program. **To find the phone number to a local domestic violence program, call the National Domestic Violence Hotline at 1-800-799-7233 or visit** [www.domesticshelters.org](http://www.domesticshelters.org).
If the counselor, advocate, social worker, or therapist needs more information about the CRS™ program before completing this application, contact NCADV at 303-839-1852 ext. 109.

Counselor / Advocate / Social Worker / Therapist / Minister COMMENTS (TYPE or PRINT neatly):

☐ I confirm that I have met with the applicant at least once. Based solely on their explanation, I believe their injuries were caused by domestic violence, and believe they are no longer experiencing domestic violence. I understand I will be contacted.

Signature: ____________________________ Date: ____________________________

Advocate Name: _______________________________________________________

Agency Mailing Address: _________________________________________________

City: ____________________________ State: ________ Zip Code: _______________

Phone: (_____) _______ - __________ Email Address (optional): __________________________

Secure business card here:

• Do you give permission to NCADV to contact you and ask about your experience with this program in about 3 months? (circle one) YES NO

• How did you hear about this program?
  ___Friend  ___Internet search  ___Newspaper  ___Magazine
  ___Agency  ___Radio  ___RV  ___Other: ______________

I verify that the statements on this application are true. I authorize release of this information to NCADV and the surgeons or doctors providing the medical care needed to repair the damage caused by domestic violence.

SIGNATURE ____________________________________ DATE ____________________________
STOP! BEFORE YOU RETURN YOUR APPLICATION, PLEASE READ THE FOLLOWING:

1) Be sure all sections of this application are filled out completely, correctly, and legibly.

2) Please do not include additional documents or photos with your application. They will not be reviewed and will be discarded.

3) Make sure you are seen by a counselor, domestic violence advocate, social worker, or therapist and have them fill out the appropriate section on Page 4.

4) Be sure to sign and date the bottom section of Page 4.

5) Make a copy of this application for your files.

6) Return the ORIGINAL application to NCADV by one method, either by mail or by email (scanned). Please do not send the application both ways.

   NCADV CRS™ Program
   One Broadway, Suite 210-B, Denver, CO 80203-3983
   mainoffice@ncadv.org

7) If your address or phone number changes, please notify NCADV as soon as possible. If we are unable to contact you, your standing in the program may be jeopardized. To reach NCADV by phone, call (303) 839-1852 x 109. You may also email us at mainoffice@ncadv.org. Be sure to clarify that you are an applicant to the program.

WHAT HAPPENS AFTER I MAIL MY APPLICATION?

- If there is a problem with your application, it will be sent back to you. Once your application is completed and if it is determined that you qualify, you will be notified in writing by NCADV that your application was received and forwarded to the appropriate medical program. If it is determined that you do not qualify, you will be notified in writing by NCADV (please note this may take several months).

- If accepted, the medical association will contact you with a referral to a medical professional as close to you as possible. Please know this process takes time and it may be 2 to 4 months before you are contacted.

- When you see the medical professional for the first time, they will let you know what they can do for you, what they cannot do for you, or whether you even qualify for the program. Since they are not being paid, the medical professionals have the final say on whether or not they can do the work that you need. There is no guarantee that you will be able to benefit from this program until you see the doctor for the first consultation. If you must cancel an appointment for any reason, notify the doctor’s office directly (failing to show up for an appointment without calling could jeopardize your standing in the program).

- While the medical professionals directly assisting you are volunteering their services for free, there is no guarantee that other services will also be free (hospital stays, prescriptions, anesthesiologists, x-rays, follow-up treatment, etc.). Talk with your doctor about how these costs can be reduced or eliminated. You may be able to use your health insurance, Medicaid, or Victim’s Compensation to help with other costs; be sure to verify this prior to any services you receive. Once paid for, costs incurred by you are not reimbursable.

NCADV CRS Application -5-