

CRIME VICTIMS' COMPENSATION PROGRAM APPLICATION

A program provided by the South Dakota Department of Social Services; providing monetary assistance to victims of violent crime.

Department of Social Services
Crime Victims' Compensation Program
700 Governors Drive
Pierre, SD 57501-2291

605-773-6317 or toll free at 1-800-696-9476 (in-state only)



SOUTH DAKOTA CRIME VICTIMS' COMPENSATION PROGRAM
South Dakota Department of Social Services
700 Governors Drive
Pierre, S.D. 57501-2291
(605) 773-6317 or 1-800-696-9476 (in-state only)
Web address: <http://dss.sd.gov/victimservices/cvc/index.asp>
Email address: VictimsServices@state.sd.us

Application Instructions

Please complete the W-9 form on the back.

1. Please type or print clearly.
2. If sufficient space is not provided on this form, use additional sheets as necessary.
3. If you need any help in completing the application, call the number above.
4. Attach all medical, hospital and/or funeral bills that you have received and that apply to this request for compensation or provide the names, addresses and telephone numbers for all providers.
5. The application must be signed by the victim, or an authorized representative. If the victim is under 18 years of age, an authorized representative must sign. In the event of death or incapacitation, an authorized representative may sign for a victim over 18 years of age. Authorized representatives signing this form must complete section III.
6. In the event of death of the victim, or if the victim is unable to sign, be sure to fill out **SECTION X & XI- Death as a result of a crime / Beneficiary/Dependent Information**. The maximum amount that may be awarded for funeral and burial expenses is \$8,000.00 including up to \$2,000.00 for a headstone and up to \$1,000.00 for miscellaneous expenses.
7. The maximum amount that may be awarded for each victim of a crime is \$15,000.00.
8. Victims' Services must be notified of any change in the applicant's address or telephone number.
9. If you do not know the answer to any question write "unknown".
10. The Application must contain a brief description of the crime (see Section V).

You **may be eligible** for compensation if you or a family member has suffered personal injury as a result of: a violent crime, trying to stop a person committing a crime, trying to help a law enforcement officer, trying to help a victim of a crime or witnessing a violent crime.

Who can apply:

An innocent victim who has suffered harm, a family member of a deceased victim, a person authorized to act on behalf of a victim or dependent and/or family members of victims under limited circumstances.

Eligibility requirements:

- The incident was reported to law enforcement within (5) days of when it could reasonably have been reported, and the victim reasonably cooperated with investigation and prosecution of the incident. If the crime was not reported within 5 days of the date that it occurred or if the victim did not reasonably cooperate, please submit a letter explaining the reason for the delay or decision not to cooperate.
- An application was filed within (1) year of the incident, except for good cause. If you are filing past 12 month, please submit a letter stating the reason for the delay.
- The compensation will not unjustly benefit the offender or an accomplice.

You must fill out every applicable section completely to have your claim processed.

**SOUTH DAKOTA
CRIME VICTIMS' COMPENSATION
APPLICATION**

RETURN TO:

Department of Social Services
Victims' Services
700 Governors Drive
Pierre SD 57501-2291

DO NOT WRITE IN THIS SPACE

CLAIM# _____

DATE RECEIVED _____

PLEASE READ INSTRUCTIONS BEFORE BEGINNING

SECTION I. Victim Information

Victim's Name: _____ Soc. Sec. No. _____

Date of Birth: ____/____/____ Age: _____ Male Female

Marital Status: Married Single Separated Divorced Widow

Mailing Address: _____

Street City State Zip Code County
Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Email Address: _____

SECTION II. Additional Information

Information required by the Department of Justice

1a. Race of victim: ____Caucasian ____Hispanic ____Black ____American Indian or Alaskan Native
____ Asian or Pacific Islander ____Other

1b. National origin of victim: if other than USA: _____

2. Did the victim have a disability before this crime occurred? Yes No Explain: _____

3. Is the victim disabled as a result of this crime? Yes No Explain: _____

4. Is the victim a South Dakota resident? Yes No Unknown

5. Was the crime a federal offense? Yes No Unknown

SECTION III. Claimant Information

(Complete Section III only if someone other than the victim is filing the claim)

Claimant Name: _____ Relationship to Victim: _____

Date of Birth: ____/____/____ Soc. Sec. No: _____

Mailing Address: _____

Street City State Zip Code
Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Email Address: _____

If you have been appointed legal guardian of the victim, please attach documentation.

SECTION IV. I learned about this program from (check one):

- Prosecuting Attorney Hospital, Doctor, etc. Brochure/Poster News Media
- Non-profit Service Agent Family Violence Shelter Relative/Friend DSS
- Counselor/Therapist Law Enforcement Victim Witness Program Internet
- Other _____

SECTION V. Crime

(Note: The crime must have occurred on or after July 1, 1992)

Location of Crime: _____

_____ Street City State Zip Code County
 Date of Crime: ____/____/____ Date Reported: ____/____/____ Law enforcement case#: _____

Law enforcement agency crime was reported to: _____

Name of person whom committed the crime? _____

Yes No Unknown Victim knew the offender? If yes, in what way? _____

Yes No Unknown Victim was related to the offender? If yes, how? _____

Yes No Unknown Was victim living in same house as the offender? If yes, is victim still living in same house as the offender? Yes No Unknown

Yes No Unknown Has the offender been charged in court?

Yes No Unknown Was the offender ordered to pay restitution? If yes, Amount ordered: _____ Amount received: _____

Yes No Unknown Is the victim or claimant considering a civil action? If yes, Name and address of attorney handling civil action: _____

Briefly describe the crime and the injuries that you incurred. Attach additional sheets if necessary:

SECTION VI. Employment and Earnings Information

Are you, or the victim that you are assisting, requesting compensation for lost wages? Yes No
(Note: The maximum amount that may be paid for lost wages is the Federal minimum wage x 40 hours, if over 40 hours a physician disability statement is required.)

Was the victim employed at the time of the injury? Yes No Part Time Full Time
If yes, complete the following. If **Self Employed** include copy of most recent Federal Income Tax return.
Please provide employer information for all employers during the 6 months prior to the crime.

Employer: _____ Contact Person: _____

Address: _____
 Street City State Zip Code

Telephone: (____) _____

Employer: _____ Contact Person: _____

Address: _____
 Street City State Zip Code

Telephone: (____) _____

Section VI: Employment and Earnings Information.....continued

Did the victim miss any time from work because of injuries from the crime? Yes No

If yes, please complete the following: _____ weeks _____ days, from (dates)_____ to _____

Has the victim returned to work? Yes No If yes, when? _____

Did the victim's wage continue while off work? Yes No If yes, complete the following:

Source (Check)	Amount per week	From (date) to (date)
___ Worker's Comp		
___ Unemployment Comp		
___ Health Plan		
___ Vacation or Sick Leave		
___ Disability Pay		
___ Other, Specify		

Check if you or the victim had or currently have income from the following:

<u>Income source</u>	<u>At the time of the crime</u>	<u>Currently</u>
Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
General Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Stamps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
T.A.N.F.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other, Specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you (or the victim) were not employed or receiving assistance at the time of injury, please list the source of income: _____

SECTION VII. Insurance or Benefits From Other Sources

Did the victim have coverage or was entitled to benefits from any of the following at the time the crime occurred?

Source	Yes	No	Identify Contact Person and Phone Number, Address and Policy/Case Number
Health Insurance	_____	_____	_____
Auto Insurance	_____	_____	_____
Life Insurance	_____	_____	_____
Disability Insurance	_____	_____	_____
Public Assistance	_____	_____	_____
Medicaid	_____	_____	_____
Medicare	_____	_____	_____
Social Security	_____	_____	_____
Worker's Compensation	_____	_____	_____
Veterans' Administration	_____	_____	_____
Indian Health Service	_____	_____	_____
Other	_____	_____	_____

SECTION VIII. Medical Bills

(Attach additional sheets if necessary)

Name & Address of Clinic/Provider	Amount of Bill to Date	Amount Paid by Victim/Claimant	Amount Paid By Others	Balance
Hospital				
Doctors				
Counseling				
Dentist				
Optician				
Ambulance				
Others				

Do you anticipate receiving more medical bills? Yes No If so, please describe: _____
Please attach copies of all bills, receipts, and insurance benefits statements.

SECTION IX. Other Expenses or Losses

(attach receipts or estimates)

(complete sections for each expense that applies)

Child Care: indicate how many _____ weeks _____ days sources were needed

Service Provider: _____

Reason service was required: _____

Amount paid by Victim/Claimant:\$ _____ By others:\$ _____ Balance Due:\$ _____

Homemaker Services: indicate how many _____ weeks _____ days sources were needed

Service Provider: _____

Reason service was required: _____

Amount paid by Victim/Claimant:\$ _____ by others:\$ _____ Balance Due:\$ _____

(check each additional expense incurred)

Transportation Reason Services were required: _____

Clothing taken as evidence (include receipts if available.)

Other _____(specify)

SECTION X. Death as a result of the crime:

(Note: If the victim died as a result of the crime, please complete the following.)

Date of Death: _____ (attach copy of Certificate of Death.)

At the time of death, did the victim contribute financial support for any dependent(s)? Yes No

If yes, amount/month \$ _____

(Attach documentation of amount such as a paystub, tax return or name and address of employer)

Did the victim have life insurance? Yes No If yes, complete the following:

Name and Address of Company : _____

Beneficiary: _____ Amount: _____ Policy Number: _____
\$ _____ # _____

SECTION X: Death as a result of the crime.....continued

Will the dependent(s) receive benefits from the following? (provide amount for each)

Yes No Social Security \$ _____ Yes No Worker's Compensation \$ _____
 Yes No Life Insurance \$ _____ Yes No Public Assistance \$ _____
 Yes No Tribal Fund \$ _____ Yes No Other \$ _____

Did the victim have burial insurance? Yes No If yes, complete the following:

Name and Address of Company: _____ Amount _____ Policy Number _____
_____ \$ _____ # _____

Name of Funeral Home: _____ Address: _____

Amount of funeral and burial expenses: \$ _____ Have expenses been paid? Yes No

If yes, by whom? Name: _____ Address: _____

Telephone: (____) _____ (Attach copies of bills; if paid, attach proof of payment)

SECTION XI. Beneficiary/Dependent Information:

(Attach additional sheets if necessary)

1. _____
Name: (Last) (First) (Middle) Sex Date of Birth

Address: Street City State Zip Relationship to Victim

2. _____
Name: (Last) (First) (Middle) Sex Date of Birth

Address: Street City State Zip Relationship to Victim

Please Date and Sign the Declaration and Authorization, the Protected Health Information form and the W9 to complete this application.

Please return to:

Department of Social Services
Victims' Services
700 Governors Drive
Pierre, SD 57501

You will receive a letter verifying receipt of your application. If you have any questions regarding the status of your claim, please feel free to call 1-800-696-9476, or 605-773-6317.

DECLARATION AND AUTHORIZATION

I declare and affirm under the penalties of perjury that the application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

If I am awarded compensation, I promise to repay the State of South Dakota Crime Victims' Compensation Program for any payments received from the person who committed this crime, whether from restitution or civil action, or from any insurance company, or any other governmental or private agency, which payments are for any injury or loss included in my claim. Further, I promise to give my written notice to the Crime Victims' Compensation Program if I pursue a claim or demand, or if I file a lawsuit for the damages sustained.

I authorize and request any person having information necessary to the administration of my claim, including all records related to this claim concerning me, to release that information to the Crime Victims' Compensation Program, South Dakota Department of Social Services. This release includes, but is not limited to law enforcement agencies, past and present employers, and any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I agree and certify that no person shall incur any legal liability to me by releasing any information pursuant to this authorization. A photocopy of this authorization shall have the same effect as the original.

Signature of Victim: _____

Authorized Representative: _____

Relationship to Victim: _____

Print Name: _____

Dated this _____ day of _____, 20 _____

**Authorization for the Use or Disclosure
Of Protected Health Information**

As required by the Health Insurance Portability and Accountability Act of 1996, the South Dakota Department of Social Services may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and return it to the Department.

(Victim Information) I hereby give my consent to release the information described below concerning:

Patient/Participant Name: _____			
Address: _____			
City: _____	State: _____	Zip Code: _____	
Date of Birth: _____	Phone #: _____	Recipient ID #: _____	

Please complete the below information for each provider. If there are more than six providers, please contact our office for additional release forms, at 605-773-6317. Please fill in dates of service at bottom of next page.

(Provider Information)The specified information is available from the following individual or entity:

Name: _____		Organization: _____	
Address: _____			
City: _____	State: _____	Zip Code: _____	

(Provider Information)The specified information is available from the following individual or entity:

Name: _____		Organization: _____	
Address: _____			
City: _____	State: _____	Zip Code: _____	

(Provider Information)The specified information is available from the following individual or entity:

Name: _____		Organization: _____	
Address: _____			

City: _____ State: _____ Zip Code: _____

(Provider Information)The specified information is available from the following individual or entity:

Name: _____ Organization: _____
Address: _____
City: _____ State: _____ Zip Code: _____

(Provider Information)The specified information is available from the following individual or entity:

Name: _____ Organization: _____
Address: _____
City: _____ State: _____ Zip Code: _____

(Provider Information)The specified information is available from the following individual or entity:

Name: _____ Organization: _____
Address: _____
City: _____ State: _____ Zip Code: _____

The specified information is to be released to the following individual or entity:

**Department of Social Services
Division of Adult Services and Aging
Victims' Services
700 Governors Drive
Pierre SD 57501-2291**

Specific information requested: medical records, itemized statements, copies of EOB's, ER reports and completed expense verification form.

Specific dates for the information requested: _____

Purpose of the disclosure: Processing of Crime Victims' Compensation Claim.

I understand the information received may include information relating to drug and/or alcohol abuse or physical/sexual abuse. The South Dakota Department of Social Services, its employees, officers, and medical providers are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

As stated in the Department's Notice of Privacy Policies, this consent form may be cancelled at any time except to the extent the staff have taken action upon it. If not cancelled, this consent to release information will terminate in **one year** or upon the following specified date: _____ . I understand that this authorization may be revoked at any time, as long as I do so in writing.

I understand if this information is released to a third party, the information may be released by the person or entity that receives the information and may no longer be protected by federal or other applicable privacy regulations. Exception -- drug and/or alcohol treatment information, HIV testing information, and mental health treatment information may not be redisclosed without my specific consent.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify. If the South Dakota Department of Social Services has been asked to allow or pay for a health care service on my behalf (such as a test or evaluation) for the purpose of providing the results of those services to someone else, I understand that if I choose not to authorize the disclosure of that information to the other person, the Department of Social Services may not allow the service or the payment for the services provided on my behalf.

Signature of participant/patient, parent, guardian, or authorized representative giving consent

Date

Print Name

Relationship to Participant/Patient

Witness Signature

Witness Name (print) and Relationship to Participant/Patient

Telephone number of the participant/patient, parent, guardian, or authorized representative for verification of the request for information

REVOCATION OF AUTHORIZATION

I hereby cancel this request to release information effective immediately:

Signature

Date

Request for Taxpayer Identification Number and Certification

**Give form to the
 requester. Do not
 send to the IRS.**

Print or type
 See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here

Signature of
 U.S. person ▶

Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,