

CRIME VICTIMS' COMPENSATION APPLICATION

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

**SOUTH DAKOTA CRIME VICTIMS' COMPENSATION
PROGRAM DEPARTMENT OF SOCIAL SERVICES
DIVISION OF ADULT SERVICES & AGING**

VICTIMS' SERVICES

700 GOVERNORS DRIVE

PIERRE, SOUTH DAKOTA 57501-2291

605.773.6317

1.800.696.9476

(in-state only)

DSS 
Strong Families - South Dakota's Foundation and Our Future

SOUTH DAKOTA CRIME VICTIMS' COMPENSATION PROGRAM
South Dakota Department of Social Services
700 Governors Drive
Pierre, S.D. 57501-2291
605.773.6317

1.800.696.9475 (in-state only)
605.773.4085 fax

Web address: <http://dss.sd.gov/victimservices/cvc/index.asp>

Email address: VictimsServices@state.sd.us

Qualifications of a secondary victim are as follows: Must be an immediate family member of the primary victim, who has experienced hardship as a result of the crime. Immediate family members may include spouse, parents, children, siblings, grandparents, and grandchildren.

Secondary 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 and/or therapy 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 secondary victim, or an authorized representative. If the secondary victim is under 18 years of age, an authorized representative must sign. In the event of incapacitation, an authorized representative may sign for a secondary victim over 18 years of age. Authorized representatives signing this form must complete section III.
6. The maximum amount that may be awarded for each secondary victim of a crime is \$15,000.00.
7. Victims' Services must be notified of any change in the applicant's address or telephone number.
8. If you do not know the answer to any question write "unknown".
9. The Application must contain a brief description of the crime (see Section V).

A person **may be** eligible for compensation if:

- The primary victims' application has been determined eligible for compensation.
- An application was filed within (1) year of the incident, except for good cause. If you are filing past 12 months, please submit a letter stating the reason for the delay.

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

**SOUTH DAKOTA
CRIME VICTIMS' COMPENSATION
SECONDARY 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. Secondary Victim Information

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

Primary Victim's Name: _____ Relationship to Primary Victim: _____

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

Marital Status: Married Single Separated Divorced Widow

Mailing Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Email: _____

SECTION II. Additional Information

Information required by the Department of Justice

1a. Race of Secondary 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 secondary victim have a disability before this crime occurred? Yes No Explain: _____

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

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

SECTION III. Secondary Claimant Information

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

Claimant Name: _____ Relationship to Secondary Victim: _____

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

Mailing Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Email: _____

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

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

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

SECTION V. Crime

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

Type of Crime: _____ Date of Crime: ____/____/____

Briefly describe the crime and how secondary victim has been affected by the crime. Attach additional sheets if necessary: _____

SECTION VI. Employment and Earnings Information

A secondary victim may be eligible for compensation for lost wages if they are the parent of a child victim or the parent or spouse of a homicide victim and employed at the time the crime was committed.

Are you, or the secondary 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 secondary victim employed at the time of the crime? 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 employment 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 secondary victim miss any time from work because of the crime? Yes No

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

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

Did the secondary 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		

SECTION VII. Insurance or Benefits From Other Sources

Did you or the secondary victim you are assisting 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	___	___	_____
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				
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. Additional Expenses or Losses

(only complete the sections for each expense that applies)

Child Care (attach receipts or estimates)

Indicate for how many _____ weeks _____ days child care was needed.

Service Provider: _____

Reason service was required: _____

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

Check each additional expense incurred: (attach receipts or estimates)

Transportation: reason transportation was required: _____

Other _____(specify)

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

VictimsServices@state.sd.us

Fax: 605.773.4085

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 or Authorized Representative: _____

Relationship to Victim: _____

Print Name(s): _____

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, as amended, the South Dakota Department of Social Services, Division of Adult Services and Aging may not use or disclose your personally identifiable 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.

Section 1: (Victim Information)

I,

Patient/Participant Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Phone #: _____ Recipient ID #: _____

hereby authorize the providers listed in Section 2 of this Authorization to release the information described in Section 3 of this Authorization, to the persons, entities or classes of persons or entities listed in Section 4 of this Authorization. I further authorize the Department of Social Services, Division of Adult Services and Aging to re-disclose information obtained from the providers in Section 2 to the other persons, entities or classes of persons or entities listed in Section 4 of this Authorization.

Section 2: (Provider Information)

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.

The specified information is available from the following individual or entity:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

The specified information is available from the following individual or entity:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

The specified information is available from the following individual or entity:

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

The specified information is available from the following individual or entity:

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

The specified information is available from the following individual or entity:

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

The specified information is available from the following individual or entity:

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

Section 3: Information Requested

Specific information requested: Medical Records, itemized statements, copies of Explanation of Benefits (EOBs), emergency room reports and completed expense verification forms.

Specific dates of service for the information requested: _____

Purpose of the disclosure: Processing Crime Victims' Compensation Claim and seeking restitution from perpetrators.

Section 4: Recipient Information

The specified information is to be released to the following persons, entities or classes of persons or entities:

- Department of Social Services
- Division of Adult Services and Aging
- Crime Victims' Compensation Program
- 700 Governors Drive
- Pierre, SD 57501

-The State's Attorney or prosecuting authority responsible for prosecuting the individual or individuals believed to be responsible for the injuries which give rise to my application to the Crime Victims' Compensation Program for compensation.

Section 6: Disclosures

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 revoked at any time except to the extent the staff have taken action upon it. If not revoked, this Authorization to release protected health 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.

Section 7: Signatures

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

Print Name _____ Relationship to Participant/Patient _____

If signed by a personal representative, provide a description of the representative's authority to act for the 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,