CRIME VICTIMS’ COMPENSATION PROGRAM

Primary Application

A program provided by South Dakota Department of Public Safety to provide monetary assistance to victims of violent crime.

Department of Public Safety
Division of Legal and Regulatory Services
Crime Victims’ Compensation Program
118 West Capitol Avenue
Pierre, SD 57501

(605) 773-6317 or toll-free at 1-800-696-9476 (in-state only)
 WHO CAN FILE AN APPLICATION?

An innocent victim who has suffered personal injury or the threat of personal injury, 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:

You may be eligible for compensation if the following requirements are met:

- You or a family member has suffered personal injury or the threat of 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.

- The crime was reported to law enforcement within five (5) days of when it could reasonably have been reported, and the victim cooperated with the investigation and prosecution of the crime. If the crime was not reported within 5 days of the date that it occurred or if the victim did not cooperate, please submit a letter explaining the reason for the delay in reporting or decision not to cooperate.

- An application must be filed within (1) year of the crime, except for good cause. If you are filing past 12 months, please submit a letter stating the reason for the delay.

- The victim did not cause or contribute to the injury or death and was not committing a crime.

- The compensation will not unjustly benefit the offender or an accomplice.

APPLICATION INSTRUCTIONS:

1. Please type or print clearly.

2. If you need any help in completing the application, call the number above.

3. You must fill out every section completely to have your claim processed. If a section does not apply to you, you may leave it blank or answer “N/A”.

4. If sufficient space is not provided on this form, use additional sheets as necessary.

5. If you do not know the answer to a question, write "unknown."

6. The application must be signed by the applicant or an authorized representative. An authorized representative would be necessary if the victim is under 18, incapacitated or deceased.

If you need any help in completing the application, call 605.773.6317.

The maximum amount that may be awarded for each victim of a crime is $15,000.
SOUTH DAKOTA CRIME VICTIMS’ COMPENSATION PROGRAM

PRIMARY APPLICATION

RETURN TO:
Department of Public Safety
Victims’ Services
118 West Capitol Avenue
Pierre SD 57501-2291

PLEASE READ INSTRUCTIONS BEFORE BEGINNING

SECTION I. Victim Information

Victims’ Services must be notified of any change in the applicant’s address or telephone number.

Victim’s Name:______________________________________________ Soc. Sec. No.____________________

Date of Birth:______/______/______ □ Male □ Female □ Other

Marital Status: □ Married □ Single □ Separated □ Divorced □ Widow

Age Range: □ 0-12 □ 13-17 □ 18-24 □ 25-59 □ 60 and older

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

1. a. Race of victim: □ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic or Latino

□ Native Hawaiian & Other Pacific Islander □ White Non-Latino/Caucasian □ Multiple Races □ Other

b. National Origin of the victim if other than the USA:__________________________________________________________

c. Applicant’s primary language:______________________________________________

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:______/______/______ Social Security Number:________________________________

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  ☐ DPS
☐ Counselor/Therapist  ☐ Law Enforcement  ☐ Victim Witness Program  ☐ Internet
☐ Other

SECTION V. Crime Information

Complete all questions within this section.

Location of Crime:

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<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
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</thead>
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Date of Crime: _____ / _____ / ______

Date Reported: _____ / _____ / ______

Law Enforcement Agency crime was reported to: __________________________________________

Law Enforcement Case #: __________________ Who 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 Victim was living in same home as the offender at the time of the crime?

☐ Yes  ☐ No  ☐ Unknown Victim currently lives in the same home as the offender?

☐ Yes  ☐ No  ☐ Unknown Offender has been charged in court?

☐ Yes  ☐ No  ☐ Unknown Offender was ordered to pay restitution? If yes, complete the following:

Amount ordered: __________________________ Amount received: __________________________

☐ Yes  ☐ No  ☐ Unknown Victim or claimant is considering a civil action suit? If yes, complete the following:

Attorney: __________________________________ Telephone: (____) _______________________

Address: __________________________________ Street ________________________

City __________________________ State ________ Zip Code ______

Briefly describe the crime and the injuries incurred (attach additional sheets if necessary):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

SECTION VI. Lost Wages as a Result of the Crime

Lost wages are paid at the Federal minimum wage.

Was the victim employed at the time of the crime? ☐ Yes  ☐ No (If no, go to Section VII.)

Is the victim requesting compensation for lost wages? ☐ Yes ☐ No (If no, go to Section VII.)

Did the victim miss any time from work as a result of 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? __________________________

<table>
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<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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</table>
A physician’s disability statement is required if over 40 hours are requested.

Did the victim continue to be paid while off work? □ Yes □ No  If yes, complete the following:

<table>
<thead>
<tr>
<th>Source (Check)</th>
<th>Amount per Week</th>
<th>From (Date) to (Date)</th>
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<td>□ Worker’s Comp</td>
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<td>□ Unemployment Comp</td>
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<td>□ Health Plan</td>
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<td>□ Vacation or Sick Leave</td>
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<td>□ Disability Pay</td>
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<tr>
<td>□ Other (Specify):</td>
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</tbody>
</table>

Provide information for all applicable employers at the time of the crime. Self-employed individuals need to include a copy of most recent Federal Income Tax Return.

Employer: ____________________________ Contact Person: ____________________________
Address: ____________________________________________
Street: ____________________________ City: ____________________________ State: ______ Zip Code: ______
Telephone: (____)________________ Fax: (____)________________ Email: ____________________________

Employer: ____________________________ Contact Person: ____________________________
Address: ____________________________________________
Street: ____________________________ City: ____________________________ State: ______ Zip Code: ______
Telephone: (____)________________ Fax: (____)________________ Email: ____________________________

SECTION VII. Insurance or Benefits from Other Sources
Indicate any coverage or benefits the victim was entitled to at the time the crime occurred.

<table>
<thead>
<tr>
<th>Source</th>
<th>Yes</th>
<th>No</th>
<th>List: Contact Person, Phone Number, Address and Policy/Case Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Auto Insurance</td>
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<tr>
<td>Life Insurance</td>
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<td>Disability Insurance</td>
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<td>Public Assistance</td>
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<td>Medicaid</td>
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<td>Social Security</td>
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<td>Worker’s Compensation</td>
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<td>Veterans Administration</td>
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<td>Indian Health Services</td>
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<tr>
<td>Other</td>
<td>☐</td>
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</tbody>
</table>
SECTION VIII. Medical Bills as a result of the Crime

Attach copies of all bills, receipts, and insurance benefits statements received that apply to this request.

<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>Amount of Bill to Date</th>
<th>Amount Paid by Victim/Claimant</th>
<th>Amount Paid By Others</th>
<th>Balance</th>
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</thead>
<tbody>
<tr>
<td>Ambulance</td>
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<tr>
<td>Hospital</td>
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<td>Doctor</td>
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<td>Counseling</td>
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<td>Dentist</td>
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<td>Optician</td>
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<td>Home Health</td>
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<tr>
<td>Others</td>
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Do you anticipate receiving more medical bills? □ Yes □ No If yes, describe:__________________________________________

SECTION IX. Other Expenses or Losses as a result of the Crime

Attach receipts or estimates.

☐ Transportation (Outside of City limits): Check all reasons for transportation that apply.
☐ Medical Treatment/Exam ☐ Mental Health ☐ Court Proceedings
☐ Law Enforcement Meeting ☐ Funeral

☐ Lodging: Check all reasons for lodging that apply.
☐ Medical Treatment/Exam ☐ Mental Health ☐ Court Proceedings
☐ Law Enforcement Meeting ☐ Funeral

☐ Clothing: Taken as evidence. List clothing items:__________________________________________

☐ Security Devices: List security devices:__________________________________________

☐ Child Care: Check all reasons for additional childcare that apply.
☐ Medical Treatment/Exam ☐ Mental Health ☐ Court Proceedings
☐ Law Enforcement Meeting ☐ Funeral

Name and address of service provider:__________________________________________

☐ Homicide Scene Expenses (Must be provided by a professional cleaning business):

Name and Address of Company:__________________________________________

Total Bill: $________________ Amount paid by Victim/Claimant: $_____________
Amount paid by Others: $_____________ Balance Due: $_____________

☐ Other (Specify):__________________________________________
SECTION X. Death as a result of the Crime
Complete this section if the victim died as a result of the crime.
Attach a copy of Certificate of Death.

Date of Death: _____/____/____

**Life Insurance:** Did the victim have life insurance? □ Yes □ No If yes, complete the following:

- Name and Address of Company: ____________________________________________________________
- Beneficiary: ___________________________ Policy Number: __________________________

**Burial Insurance:** Did the victim have burial insurance? □ Yes □ No If yes, complete the following:

- Name and Address of Company: ____________________________________________________________
- Policy Number: __________________________

**Funeral Expenses:** Amount of funeral and burial expenses: $ ______________________

- Name and Address of Funeral Home: __________________________________________________________
- Have funeral and burial expenses been paid? □ Yes □ No If yes, complete the following:
- Name of Payer: ___________________________ Address: ____________________________________________
- Telephone: (___) _______________________

**Headstone Expenses:** Amount for headstone: $ ______________________

- Name and Address of Monument Company: __________________________________________________________
- Have expenses been paid for the headstone? □ Yes □ No If yes, complete the following:
- Name of Payer: ___________________________ Address: ____________________________________________
- Telephone: (___) _______________________

**Memorial and Miscellaneous Expenses:** Amount of memorial expenses: $ ______________________

- Have expenses been paid for the memorial? □ Yes □ No If yes, complete the following:
- Name of Payer: ___________________________ Address: ____________________________________________
- Telephone: (___) _______________________

The maximum amount of $8,000 may be awarded for funeral and burial expenses, which may include up to $500 for miscellaneous expenses.
At the time of death, did the victim contribute financial support for any dependent(s)?  ☐ Yes ☐ No

If yes, amount/month: $________________________

Provide the following information about the victim’s dependent(s). Attach additional sheets if needed.

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

3.

Name: Last First Middle Sex Date of Birth

Address: Street City State Zip Relationship to Victim
Please return completed application to:
Department of Public Safety
Crime Victims' Compensation Program
118 West Capitol Avenue
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 605.773.6317.

Completed applications include:
☐ Sections completed that are relevant to the applicant.
☐ Any required attachments such as: bills, receipts, insurance, Certificate of Death, etc.
☐ Signed, dated and witness signature on the Authorization for the Use or Disclosure of Protected Health Information, page 11-12.

Incomplete applications will be returned to the applicant.
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 the 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 Public Safety. 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 _____
## Section 1: Victim Information

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<th>Patient/Participant Name:</th>
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I, the above-named Patient/Participant, 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 Public Safety 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:

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</table>
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 Public Safety
  Crime Victims’ Compensation Program
  118 West Capitol Avenue
  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 5: 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 Public Safety, its employees, officers, and medical providers are hereby released from any legal responsibility or liability for the 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 has acted 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 Public Safety 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 Public Safety 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 Public Safety may not allow the service or the payment for the services provided on my behalf.

Section 6: 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
Form W-9

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:

☐ Individual/sole proprietor
☐ C Corporation
☐ S Corporation
☐ Partnership
☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
☐ Other (see instructions) ▶

Exemptions (see instructions):

Exempt payee code (if any) ▶
Exemption from FATCA reporting code (if any) ▶

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

Requester’s name and address (optional)

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 the "Name" line 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.

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

Social security number ▶
Employer identification number ▶

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), and

4. I have the FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are 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 3.

Signature of U.S. person ▶

Date ▶

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at www.irs.gov/w9. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

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, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest 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, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and 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 under section 1446 on any foreign partners’ share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 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 section 1446 withholding on your share of partnership income.
Notice of Nondiscrimination

As a recipient of Federal financial assistance and a State or local governmental agency, the Department of Public Safety does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission or access to, or treatment or employment in, its programs, activities, or services, whether carried out by the Department of Public Safety directly or through a contractor or any other entity with which the Department of Public Safety arranges to carry out its programs and activities; or on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in, its programs, activities, or services when carried out by the Department of Public Safety directly or when carried out by sub-recipients of grants issued by the United States Department of Justice, Office on Violence against Women.

The Department of Public Safety:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters

If you need these services, contact your local victim services in your area. For assistance locating those services in your area, contact DPS Victim Services.

If you believe that DPS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a discrimination complaint or grievance with: Director of DPS Division of Legal & Regulatory Services, 118 West Capitol Avenue, Pierre, SD 57501. Phone: (605)773-3178, Fax: (605)773-2955, DPSInfo@state.sd.us. You can file a discrimination complaint or grievance in person or by mail, fax, or email.


This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations (CFR) Parts 80, 84, and 91, and 28 CFR Part 35, the Omnibus Crime Control and Safe Streets Act of 1968, Title IX of the Education Amendments of 1972, Equal Treatment for Faith-based Religions at 28 CFR Part 38, the Violence Against Women Reauthorization Act of 2013, and Section 1557 of the Affordable Care Act.