Crime Victims' Compensation Program Secondary Application

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

SOUTH DAKOTA CRIME VICTIMS' COMPENSATION PROGRAM
DEPARTMENT OF SOCIAL SERVICES
VICTIMS' SERVICES
700 GOVERNORS DRIVE
PIERRE, SOUTH DAKOTA 57501-2291
605.773.6317
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
1.800.696.9476 (in-state only)
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):

☐ 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)

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

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, 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 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
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

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REVOCATION OF AUTHORIZATION

I hereby cancel this request to release information effective immediately:

_____

Signature — Date

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

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. 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 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 for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Notice of Nondiscrimination

As a recipient of Federal financial assistance and a State or local governmental agency, the Department of Social Services 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 Social Services directly or through a contractor or any other entity with which the Department of Social Services 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 Social Services 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 Social Services:

- 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
    - Information written in other languages

If you need these services, contact your local DSS office.

If you believe that DSS 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: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501. Phone: (605) 773-3305, Fax: (605) 773-7223, DSSInfo@state.sd.us . You can file a discrimination complaint or grievance in person or by mail, fax, or email. If you need help filing a discrimination complaint or grievance, the Discrimination Coordinator, Director of DSS Division of Legal Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

Language Assistance

1. **Español (Spanish) -** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305-9673 (TTY: 711).

2. **Deutsch (German) -** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).

3. **繁體中文 (Chinese) -** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-305-9673（TTY：711）

4. **unD (Karen) -** ymol.ymo;=erh>uwdR unDusdmtCd< erRM> usdmtw>rRpXRvX wvXmbl.vXmphR eDwrHRb.ohM.vDRI ud;1-800-305-9673 (TTY: 711).

5. **Tiếng Việt (Vietnamese) -** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-305-9673 (TTY: 711).

6. **नेपाली (Nepali) -** t.यान दनुहोस:् तपाइ ले नेपाल बो नह छ भन तपाइ को ि न त भाषा सहायता सवाह नःश क पमा उपल ध छ । फोन गनुहोसर् ्1-800-305-9673 (ट टवाइ: 711)

7. **Srpsko-hrvatski (Serbo-Croatian) -** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-305-9673 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 711).

8. **አማርኛ (Amharic) -** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-305-9673 (መስማት ለተሳናቸው: 711).

9. Sudanic **Adamawa (Fulfulde)** MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-305-9673 (TTY: 711).

10. **Tagalog (Tagalog – Filipino) -** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-305-9673 (TTY: 711).

11. **한국어 (Korean) -** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-305-9673 (TTY: 711)번으로 전화해 주십시오.

12. **Русский (Russian) -** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-305-9673 (телетайп: 711).

13. **Cushite Oroomiffa (Oromo) -** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-305-9673 (TTY: 711).

14. Український (Ukrainian) - УВАГА: Якщо ви говорити українською мовою, перекладацькі послуги, безкоштовно, доступні для вас. Телефонуйте. Телефонуйте 1-800-305-9643 (TTY: 711).

15. **Français (French) -** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-305-9673 (ATS : 711).

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