Crime Victims' Compensation Program Primary Application

A program provided by the South Dakota Department of Social Services to provide 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)

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

SOUTH DAKOTA CRIME VICTIMS' COMPENSATION PROGRAM

South Dakota Department of Social Services, Crime Victims' Compensation Program
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

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 (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. You must fill out every applicable section completely to have your claim processed.
3. If sufficient space is not provided on this form, use additional sheets as necessary.
4. If you do not know the answer to a question, write "unknown".
5. 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 in the event of death.

   If you need any help in completing the application, call 605.773.6317 or 1.800.696.9476 (in state only).

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 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

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: ____/____/_____ Age: _____ ☐ Male ☐ Female ☐ Other

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

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 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: _____/_____/_____ Social Security Number: _____

Mailing Address: _____
Street City State Zip Code

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

Cell Phone: (____)_____ Email Address: _____

Legal guardian of the victim must attach a copy of the guardianship document.

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 Information

Complete all questions within this section.

Location of Crime: _____
Street City State Zip Code County

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?_____

A physician's disability statement is required if over 40 hours are requested.

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):		

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.

Source	Yes	No	Identify Contact Person, 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 Services	☐	☐	_____
Other	☐	☐	_____

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.

Name of Provider	Amount of Bill to Date	Amount Paid by Victim/Claimant	Amount Paid By Others	Balance
Ambulance				
Hospital				
Doctor				
Counseling				
Dentist				
Optician				
Home Health				
Others				

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 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 includes up to $500 for miscellaneous expenses.

SECTION XI. Beneficiary/Dependent Information

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 Social Services

Crime Victims' Compensation Program

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 (in state only)** or **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 and dated Declaration and Authorization, page 10.
- ☐ Signed, dated and witness signature on the Authorization for the Use or Disclosure of Protected Health Information, page 11-12.
- ☐ Signed and dated W-9, page 13.

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 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. August 2013)
Department of the Treasury
Internal Revenue Service

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/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.)

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 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. 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 on page 3.

Sign Here | **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 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, 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.

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) -** ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီကျိာ်အယိ, နမၤနှ်ၤ ကျိာ်အတၢ်မၤစၢၤလ၊ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး1-800-305-9673 (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) -** ध्यान □दनुहोस:् तपाइ□ले नेपाल□ बोल्नहन्छ भन तपाइ□को □निम्त भाषा सहायता सवाहरू □नःशल्क रूपमा उपलब्ध 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 ኣማርኛ 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

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.