SOUTH DAKOTA DEPARTMENT OF PUBLIC SAFETY

CRIME VICTIMS' COMPENSATION PROGRAM

Secondary 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)

SOUTH DAKOTA CRIME VICTIMS' COMPENSATION PROGRAM
South Dakota Department of Public Safety
118 West Capitol Ave
Pierre, S.D. 57501-2291
605.773.6317
1.800.696.9476 (in-state only)
Web address: https://dps.sd.gov/victims-services/crime-victims-compensation
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. If you have been appointed legal guardian of the victim, please attach documentation.

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.

If a section does not apply to you, you may leave it black or indicate "N/A".

SOUTH DAKOTA
CRIME VICTIMS' COMPENSATION
SECONDARY APPLICATION

RETURN TO:

Department of Public Safety
Victims' Services Program
118 West Capitol Avenue
Pierre SD 57501

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:_____/____/______ ☐ Male ☐ Female

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

Home Phone: (____)__________________________Work Phone: (_____)______________________________

Cell Phone: (____)_____________________________Email:____

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 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 ☐ DPS
☐ 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 the 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 a 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	List: 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 how many weeks_________ days__________ childcare 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 Public Safety
Victims' Services
118 West Capitol Avenue
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 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 __________

Authorization for the Use or Disclosure

Section 1: ***Victim Information***

Patient/Participant Name: ____

Address: ____

City: ____________________ State: ____________________ Zip Code: ____________________

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

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, Office of Victim 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 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 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 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

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REVOCATION OF AUTHORIZATION

I hereby cancel this request to release information effective immediately:

____

Signature Date

Form **W-9**
(Rev. October 2007)
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, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ....
☐ Other (see instructions) ▶

☐ Exempt payee

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.

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

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).

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,

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 DPS office.

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 and 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.

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.