CRIME VICTIMS' COMPENSATION PROGRAM APPLICATION

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

Department of Social Services
Division of Adult Services and Aging
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)

SOUTH DAKOTA CRIME VICTIMS' COMPENSATION PROGRAM
South Dakota Department of Social Services, Division Of Adult Services & Aging, Victims' 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/elderlyservices/services/cvc/index.asp
Email address: Victims@state.sd.us

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, hospital and/or funeral 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 victim, or an authorized representative. If the victim is under 18 years of age, an authorized representative must sign. In the event of death or incapacitation, an authorized representative may sign for a victim over 18 years of age. Authorized representatives signing this form must complete section III.
6. In the event of death of the victim, or if the victim is unable to sign, be sure to fill out **SECTION X & XI- Death as a result of a crime / Beneficiary/Dependent Information**. The maximum amount that may be awarded for funeral and burial expenses is $6,500.00 including up to $1,200.00 for a headstone and up to $500.00 for miscellaneous expenses.
7. The maximum amount that may be awarded for each victim of a crime is $15,000.00.
8. Victims' Services must be notified of any change in the applicant's address or telephone number.
9. If you do not know the answer to any question write "unknown".
10. The Application must contain a brief description of the crime (see Section V).

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

• He/she has been the victim of or witness to a violent crime which resulted in personal injury or death or he/she is the parent of a child abuse victim, a spouse of a rape victim or a family member of a homicide victim.

• The injury occurred as result of a crime, trying to apprehend a person committing a crime, trying to help a law enforcement officer, or trying to prevent a crime.

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

• 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.

• 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.

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

SOUTH DAKOTA
CRIME VICTIMS'COMPENSATION
APPLICATION

RETURN TO:

Department of Social Services
Division of Adult Services and Aging
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

Victim's Name:____ Soc. Sec. No.______________________

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

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

Mailing Address:____
Street City State Zip Code County

Home Phone: (____)_________________________ Work Phone: (____)______________________________

Cell Phone: (____)___________________________

SECTION II. Additional Information
Information required by the Department of Justice

1a. Race of 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 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:____/____/____ Soc. Sec. No:____

Mailing Address:____
Street City State Zip Code

Home Phone: (____)_______________________ Work Phone: (____)________________________________

Cell Phone: (____)__________________________

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)

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 Was victim living in same house as the offender? If yes, is victim still living in same house as the offender? ☐ Yes ☐ No ☐ Unknown

☐ Yes ☐ No ☐ Unknown Has the offender been charged in court?

☐ Yes ☐ No ☐ Unknown Was the offender ordered to pay restitution? If yes,
Amount ordered:________________ Amount received:_____________________

☐ Yes ☐ No ☐ Unknown Is the victim or claimant considering a civil action? If yes,
Name and address of attorney handling civil action:________________________
____

Briefly describe the crime and the injuries that you incurred. Attach additional sheets if necessary:
____
____
____
____

SECTION VI. Employment and Earnings Information

Are you, or the 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 victim employed at the time of the injury? ☐ 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 employers 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 victim miss any time from work because of injuries from 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?____

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		

Check if you or the victim had or currently have income from the following:

Income source	At the time of the crime	Currently
Social Security	☐ Yes ☐ No	☐ Yes ☐ No
Social Security Disability	☐ Yes ☐ No	☐ Yes ☐ No
General Assistance	☐ Yes ☐ No	☐ Yes ☐ No
Food Stamps	☐ Yes ☐ No	☐ Yes ☐ No
T.A.N.F.	☐ Yes ☐ No	☐ Yes ☐ No
Other, Specify:____________________	☐ Yes ☐ No	☐ Yes ☐ No

If you (or the victim) was not employed or receiving assistance at the time of injury, please list the source of income:____

SECTION VII. Insurance or Benefits From Other Sources

Did the victim 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	____	____	____
Auto Insurance	____	____	____
Life 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				
Dentist				
Optician				
Ambulance				
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 Victim/Claimant:$________________ By others:$______________Balance Due:$_______________

Homemaker Services (attach receipts or estimates)

Indicate how many ___________ weeks ___________ days homemaker services were needed.

Service Provider:____

Reason service was required:____

Amount paid by Victim/Claimant:$________________ by others:$______________Balance Due:$_______________

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

☐ Transportation: reason transportation was required:____

☐ Clothing taken as evidence (include receipts if available)

☐ Other ____(specify)

SECTION X. Death as a result of the crime:

(Note: If the victim died as a result of the crime, please complete the following.)

Date of Death:____ (attach copy of Certificate of Death.)
At the time of death, did the victim contribute financial support for any dependent(s)? ☐ Yes ☐ No
If yes, amount/month $____________
(Attach documentation of amount such as a paystub, tax return or name and address of employer)

Did the victim have life insurance? ☐ Yes ☐ No If yes, complete the following:

Name and Address of Company :____

____ $_________________ # __________________________
Beneficiary: Amount: Policy Number:

SECTION X: Death as a result of the crime………continued

Will the dependent(s) receive benefits from the following? (provide amount for each)

☐ Yes ☐ No Social Security $________ ☐ Yes ☐ No Worker's Compensation $________
☐ Yes ☐ No Life Insurance $________ ☐ Yes ☐ No Public Assistance $________
☐ Yes ☐ No Tribal Fund $________ ☐ Yes ☐ No Other $________

Did the victim have burial insurance? ☐ Yes ☐ No If yes, complete the following:

____ $_________________ #_________________________
Name and Address of Company: Amount: Policy Number:

Name of Funeral Home:______________________________ Address:___________________________________

Amount of funeral and burial expenses: $____________ Have expenses been paid? ☐ Yes ☐ No

If yes, by whom? Name:______________________________ Address:___________________________________

Telephone: (____)___________________________ (Attach copies of bills; if paid, attach proof of payment)

SECTION XI. Beneficiary/Dependent Information:

(Attach additional sheets if necessary)

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

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
Division of Adult Services and Aging
Victims' Services
700 Governors Drive
Pierre SD 57501

You will receive a letter verifying receipt of your application within two weeks. 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: ____

Authorized Representative: ____

Relationship to Victim: ____

Print Name: ____

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, the South Dakota Department of Social Services may not use or disclose your 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.

(Victim Information) I hereby give my consent to release the information described below concerning:

Patient/Participant Name: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

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

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. Please fill in dates of service at bottom of next page.

(Provider Information)The specified information is available from the following individual or entity:

Name: ____________________ Organization: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

(Provider Information)The specified information is available from the following individual or entity:

Name: ____________________ Organization: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

(Provider Information)The specified information is available from the following individual or entity:

Name: ____________________ Organization: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

(Provider Information)The specified information is available from the following individual or entity:

Name: ____ Organization: _________________________________

Address: ____

City: _________________________________ State: ___________________ Zip Code: ___________________

(Provider Information)The specified information is available from the following individual or entity:

Name: ____ Organization: _________________________________

Address: ____

City: _________________________________ State: ___________________ Zip Code: ___________________

(Provider Information)The specified information is available from the following individual or entity:

Name: ____ Organization: _________________________________

Address: ____

City: _________________________________ State: ___________________ Zip Code: ___________________

The specified information is to be released to the following individual or entity:

Department of Social Services
Division of Adult Services and Aging
Victims' Services
700 Governors Drive
Pierre SD 57501-2291

Specific information requested: medical records, itemized statements, copies of EOB's, ER reports and completed expense verification form.

Specific dates for the information requested: ____

Purpose of the disclosure: Processing of Crime Victims' Compensation Claim.

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 cancelled at any time except to the extent the staff have taken action upon it. If not cancelled, this consent to release 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.

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

Print Name — Relationship to Participant/Patient

Witness Signature — Witness Name (print) and Relationship to 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 Date