CRIME VICTIM COMPENSATION PROGRAM

Capitol Hill Building, 320 W. 25th Street, 2nd Floor, Cheyenne, WY 82002
Phone (307) 777-7200 Victim Toll-Free (888) 996-8816 Fax (307) 777-6683
E-mail: ag-victimservices@wyo.gov Website: victimservices.wyoming.gov

VICTIM INFORMATION	Victim Name		
Mailing Address	City	State	Zip Code
Primary Phone #	E-mail		
Gender ❑ Male ❑ Female	Age	Date of Birth	Social Security #

For Federal Statistical Purposes Only

Race
❑ Caucasian ❑ Hispanic ❑ African American ❑ Native American ❑ Asian or Pacific Islander ❑ Multi-Racial

Disabled (prior to crime) ❑ Yes ❑ No	Disabled (as a result of crime) ❑ Yes ❑ No
Wyoming Resident ❑ Yes ❑ No	Federal Crime ❑ Yes ❑ No

CLAIMANT INFORMATION	Section must to be completed if victim is: ❑ deceased ❑ incompetent ❑ minor	Relationship to Victim
Claimant Name	Social Security #	Date of Birth

Mailing Address	City	State	Zip Code
Primary Phone #	E-mail		

REFERRAL SOURCE	**This section to be filled out by Victim Advocate filling out application**

Name of Advocate ______________________________ Agency Name ______________________________
Address ____
Phone Number ___________________________ E-mail Address ______________________________

CRIME INFORMATION	**ATTACH LAW ENFORCEMENT REPORT & CERTIFICATION**

Crime Date	Date Reported	Case #

Type of Crime: ❑ Assault ❑ Child Physical Abuse ❑ Child Sexual Abuse ❑ Domestic Violence
❑ DWI ❑ Homicide ❑ Sexual Assault ❑ Stalking ❑ Other (explain) ____________________

Crime Reported to: ❑ Police ❑ Sheriff ❑ Highway Patrol ❑ FBI ❑ BIA ❑ Nat'l Park ❑ Other ________________________	Responding Officer or Detective:

Location of Crime	City	County	State

Claim #____________________
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OFFENDER INFORMATION	Has an arrest been made? ❑ Yes ❑ No ❑ Unknown	Name of Offender(s)

CIVIL SUIT	**The Division of Victim Services must be notified if a civil suit is filed.**

Do you plan to file a civil suit? ❑ Yes ❑ No ❑ Unknown at this time

If so, who is your attorney? Name ______________________________

Address ______________________________

Phone ____________________ Outcome of civil suit ____________________

INSURANCE/OTHER COLLATERAL SOURCES	**All bills must be submitted to your insurance carrier or other sources before applying. Please attach copy of insurance card.**

Was the victim covered by health insurance or assistance plan at the time of the crime? ❑ Yes (check all that apply) ❑ No

❑ Commercial/Private Health Ins.	❑ Medicare/Medicaid/Title 19	❑ VA/Military Insurance
❑ Indian Health Services	❑ Accident/Life Insurance **Must be included if victim is deceased**	❑ Home Owner/Renters Insurance
❑ Victim Auto Insurance **Must be included if auto related crime**	❑ Offender Auto Insurance **Must be included if auto related crime**	❑ Social Security/SSI/SSDI
❑ Workers/Unemployment Comp	❑ Other (please explain)	

FUNERAL/BURIAL EXPENSES	**Attach itemized copies of funeral/burial bills. ($5000 maximum benefit)**

Name of Funeral Home ____________________ Life Insurance company name ____________________

Funeral Home address/phone number ______________________________

Other expenses ______________________________

MEDICAL/DENTAL/RX/ COUNSELING SERVICES	**Attach all itemized bills related to crime.** **Attach insurance Explanation of Benefits.**
LOSS OF EARNINGS ***Must be employed at time of crime.***	**Attach Employee Certification completed by Victim's Employer.** **If self-employed, please complete Self Employment Verification of Lost Wages.**
LOSS OF SUPPORT ***Must be completed at time of crime.***	**Completed in the event of the death of victim or victim is incapacitated, was a source of support for the family, and no longer able to contribute.**
CATASTROPHIC INJURY	**Partial or permanent disability of limbs, sight, hearing, or speech as a direct result of crime. Include receipts/estimates of home/vehicle improvement or devices. ($10,000 maximum benefit)**

Type of disability ____________________ Name of doctor to verify disability ____________________

Address ______________________________ Phone number ____________________

OTHER ECONOMIC EXPENSES	**Attach receipts/bills/estimates for replacement items or clean-up costs. Must file insurance first. Check all that apply.**

❑ Personal articles taken as evidence ($500 maximum benefit). Identify articles/estimate value

❑ Crime scene clean-up ($2500 maximum benefit). **If there is homeowner/rental insurance, this must be filed first.**

❑ Transportation/Mileage ❑ Relocation Expenses ❑ Other Losses:

Before sending this application, make sure to:

❑ Sign/date following authorization page

❑ Attach copies of bills, estimates, and receipts

❑ Attach LEC and summary of crime and injuries

❑ Complete all appropriate sections of application

STATEMENT OF UNDERSTANDING

I understand after receiving this application, the Division of Victim Services Compensation Program staff will investigate the accuracy and truthfulness of the information given on this form and any other necessary matters regarding this claim, and I consent to such investigation.

I understand the Division may release records in their control, and seek records from other agencies, in connection with my claim relating to any compensation awarded to me or paid on my behalf. This includes, but is not limited to, the prosecuting attorney's office, probation and parole, and other parts of the federal or state court system, as they seek restitution from the defendant.

I understand I am required, and I hereby agree, to notify the Division if I hire an attorney to represent me in a lawsuit related to the crime that led me to file this application. I also agree to notify the Division if the offender offers to reimburse me for my losses.

I understand the Division is the payer of last resort. It is my responsibility to make sure all other forms of payment have been exhausted. If other forms of payment become available during the processing of the application, I will notify the Division. Otherwise, failure to provide this information may jeopardize my eligibility for compensation.

I understand based on W.S. 14-3-205, the Division of Victim Services is required to report suspected child abuse to the proper authorities.

ASSIGNMENT OF BENEFITS (DIRECT PAYMENT TO SERVICE PROVIDERS)

From any award made by the Division of Victim Services Compensation Program, I give permission to the Division to pay any applicable unpaid bills directly to the appropriate parties.

AGREEMENT OF VICTIM/CLAIMANT

I hereby agree to repay the Division of Victim Services the amount of the award, or as much as recovered, if I recover payment from the person or persons responsible for the injuries for which I am seeking compensation, as outlined by Wyoming Statute 1-40-112(a). I understand this includes repaying the Division if I recover any amount from the offender, his/her insurance company, his/her employer's insurance company, or any other entity who is paying on behalf of the offender for the damages sustained by me due to the crime described in this application.

AUTHORIZATION TO OBTAIN RECORDS, RELEASE OF INFORMATION, AND TO CONDUCT AN INVESTIGATION TO REVIEW AND EVALUATE MY CLAIM

I give permission to any hospital, doctor, federal, state, or local law enforcement agency, insurance agency/company, employer, social service agency, or any federal, state or local government agency, including the Social Security Administration, and privately retained attorneys to release all records, to answer any questions, and to provide any information to assist the Division in processing this compensation claim. I also give my consent to the Division to exercise its own discretion in releasing or withholding information regarding my crime-related losses to any person or entity responsible for submitting restitution requests to the court. I understand this information will be confined to an itemization of my crime-related monetary losses, in so far as the Division is aware of them. I agree the Division may release information regardless of whether I have received a compensation award. I understand this information will be released only for the purpose of obtaining an order of restitution from the defendant(s) or for determining eligibility for compensation. Furthermore, I understand this release form which I have signed in no way obligates the Division to release information, to gather and present more information than it already possesses, to pursue an order of restitution on my behalf or to pursue collection of restitution on my behalf. I understand the issue of restitution collection rests solely with the court system and not with the Division.

I also understand the limitations of this agreement in no way limits the Division's ability to pursue its own revenue recovery to the extent it provides me with compensation benefits.

This authorization is valid for two years from the date given below. A photo copy of this authorization is as effective and valid as the original.

I certify under penalty of perjury and subject to the provisions of W.S. § 1-40-102 through 119 and its penalties, the foregoing claim is true and a just record of expenses incurred by me as a result of the crime against me. I further certify under penalty of perjury I have read and understand the statements above including the "Statement of Understanding" and "Agreement of Victim/Claimant" and I agree to them. **(Should be signed by victim 18 years or older, an emancipated minor, or their parent or guardian.)**

FORM MUST BE COMPLETED AND SIGNED TO RECEIVE COMPENSATION

Victim Name	Claimant Name
Victim Social Security Number	Claimant Social Security Number
Street Address or Box Number	Street Address or Box Number
City, State, Zip	City, State, Zip
Signature of Victim or Claimant **18 years of age or older**	Date Signed

Return to: Division of Victim Services, 320 W. 25th Street, 2nd Floor, Cheyenne, WY 82002.
For assistance with completing this application, call toll- free at 1-888-996-8816 or 1-307-777-7200.

RETURN TO:
DIVISION OF VICTIM SERVICES
320 West 25 Street, 2nd Floor
CHEYENNE, WY 82002
PHONE (307) 777-7200
FAX (307) 777-6683

WOLFS-109
Attorney General Office Use Only

STATE OF WYOMING

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER & CERTIFICATION

PLEASE PRINT OR TYPE: Forms that are illegible or incomplete will not be processed.

PURPOSE OF THE FORM: The State of Wyoming is required to file an information return with the IRS and must have your correct Taxpayer Identification Number (TIN) to report.

IRS regulations provide the following: If you fail to furnish your correct TIN to a requestor, you may be subject to a penalty
of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect. If you make a false statement with no reasonable basis that results in no backup withholding, you may be subject to a $500 penalty. If you willfully falsify certifications or affirmations you may be subject to criminal penalties including fines and/or imprisonment.

☐ Individual/Sole Proprietor

NUMBER: ______________________ (SSN) **NAME:** ______________________ (Official Tax Reporting Name)

MAILING ADDRESS: **(Number, Street, and Apt. or PO Box):** ______________________

____
CITY STATE ZIP

PHONE NUMBER: (Include area code) ______________ **FAX:** (Include area code) ______________

I CERTIFY UNDER PENALTY OF PERJURY 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),
*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 IRS that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
3. I certify I am a U.S. Citizen

* *You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return.*

SIGNATURE: ______________________ **DATE:** ________

IN ORDER TO RECEIVE APPROVED BENEFITS,
THIS FORM MUST BE COMPLETED, SIGNED AND DATED!!

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