

**OFFICE OF THE ATTORNEY GENERAL- STATE OF WYOMING
DIVISION OF VICTIM SERVICES - COMPENSATION PROGRAM**

ASSOCIATED VICTIM APPLICATION

*122 W. 25th St., Herschler Building – 1st Floor West
Cheyenne, WY 82002*

Phone (307) 777-7200 Victim Toll Free (888) 996-8816

E-mail: victimservices@state.wy.us

Website: victimservices.wyoming.gov

DOCUMENTATION AND/OR RECEIPTS OF LOSSES ARE REQUIRED



					Claim #: (CVC Use Only)	
Name of Associated Victim/Family Member Seeking Benefits:						Social Security #:
Address:				City:	State:	Zip:
Date of Birth:	Telephone: h: _____ w: _____	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Relationship to Primary Victim (check only one):			
		<input type="checkbox"/> Spouse	<input type="checkbox"/> Sibling	<input type="checkbox"/> Household Member		
		<input type="checkbox"/> Child	<input type="checkbox"/> Parent	<input type="checkbox"/> Other _____		
Name of Primary Victim:			Date of Crime:	Date Crime Reported:		
Was a claim filed for crime victims benefits on the primary victim? <input type="checkbox"/> yes <input type="checkbox"/> no						
Type of crime: <input type="checkbox"/> Homicide <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Child Sexual Assault <input type="checkbox"/> Other _____						
Name of mental health counselor:			Address of mental health counselor:			
			Phone: _____			
Check other sources which may be available to pay for your counseling:						
<input type="checkbox"/> Health Insurance		<input type="checkbox"/> Indian Health Services				
<input type="checkbox"/> Medicare		<input type="checkbox"/> Employee Assistance Program				
<input type="checkbox"/> Medicaid		<input type="checkbox"/> Other (explain) _____				
<input type="checkbox"/> Veteran's Benefits		<input type="checkbox"/> None				
If any of the above resources are checked, please give company name, address & policy number(s) and name of insured below:						
Name: _____		Address: _____			Policy #: _____	
Other economic losses to be considered:						
<input type="checkbox"/> Mileage <input type="checkbox"/> Food <input type="checkbox"/> Lodging <input type="checkbox"/> Lost Wages <input type="checkbox"/> Other (Specify) _____						
Please explain what the above expenses were used for: _____						
The following information is used for statistical purposes only. It is needed to comply with federal regulations:						
Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No	Age: <input type="checkbox"/> 17 - under	Race: <input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> 18 - 63	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian/Pacific Islander			
	<input type="checkbox"/> 64 - over	<input type="checkbox"/> African American	<input type="checkbox"/> Multi-racial			
Who referred you? <input type="checkbox"/> Victim/witness coordinator <input type="checkbox"/> Family violence shelter <input type="checkbox"/> Law enforcement agency <input type="checkbox"/> Counselor						
<input type="checkbox"/> Court System <input type="checkbox"/> Probation & Parole <input type="checkbox"/> Attorney <input type="checkbox"/> Hospital/Dr. <input type="checkbox"/> News Media <input type="checkbox"/> Brochure <input type="checkbox"/> Other						

REPAYMENT AND SUBROGATION AGREEMENT

I understand that Wyoming law requires me to contact and repay the Division of Victim Services - Compensation Program if I receive payments from the offender, a civil lawsuit, an insurance program, or any other government or private agency after I receive payment from the compensation program. I also agree to notify the division if I hire an attorney to represent me in any action related to this crime.

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 agree that the Division may release information regardless of whether I have received a compensation award. I understand that 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 that 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 that the issue of restitution collection rests solely with the court system and not with the Division.

I understand that the Division is the payer of last resort. It is my responsibility to make sure that 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.

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 the information in this application is true and correct to the best of my knowledge. I understand my signature says I agree to all statements specified in this agreement.

FORM MUST BE COMPLETED AND SIGNED TO RECEIVE COMPENSATION

Signature

Date

Signature of Legal Guardian (required if associated victim is minor)

Date

Social Security Number
(SSN of legal guardian if associated victim is minor)

Street Address or Box Number

City, State, Zip