

Claim # \_\_\_\_\_  
For Office Use Only

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



122 W. 25<sup>th</sup>, Herschler Bldg., 1<sup>st</sup> Floor West, Cheyenne, WY 82002

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

Fax (307)777-6683

E-mail: [yssi@state.wy.us](mailto:yssi@state.wy.us) Website: [yssi.state.wy.us](http://yssi.state.wy.us)

**AN INCOMPLETE APPLICATION WILL BE RETURNED**

<b>VICTIM INFORMATION</b>		Victim Name			
Mailing Address			City	State	Zip Code
Home/Daytime Phone # ( ) ( )		Work/Message Phone # ( ) ( )		E-mail	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth / /	Social Security #		
<b>For Federal Statistical Purposes Only</b>					
Race <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Multi-Racial					
Disabled (prior to crime) <input type="checkbox"/> Yes <input type="checkbox"/> No			Disabled (as a result of crime) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Wyoming Resident <input type="checkbox"/> Yes <input type="checkbox"/> No			Federal Crime <input type="checkbox"/> Yes <input type="checkbox"/> No (See instructions for explanation)		
<b>CLAIMANT INFORMATION</b>		Section must be completed if the victim is: <input type="checkbox"/> deceased <input type="checkbox"/> incompetent <input type="checkbox"/> minor		Relationship to Victim	
Claimant Name			Social Security #	Date of Birth / /	
Mailing Address			City	State	Zip Code
Home/Daytime Phone # ( ) ( )		Work /Message Phone# ( ) ( )		E-Mail	
<b>CRIME INFORMATION</b>		<b>♦ ATTACH LAW ENFORCEMENT REPORT &amp; CERTIFICATION ♦ THIS SECTION MUST BE COMPLETED</b>			
Crime Date / /	Crime Reported / /	Case #			
Type of Crime: <input type="checkbox"/> Assault <input type="checkbox"/> Child Physical Abuse <input type="checkbox"/> Child Sexual Abuse <input type="checkbox"/> Domestic Violence <input type="checkbox"/> DWI <input type="checkbox"/> Homicide <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Stalking <input type="checkbox"/> Other					
Crime Reported to: <input type="checkbox"/> Police <input type="checkbox"/> Sheriff <input type="checkbox"/> Highway Patrol <input type="checkbox"/> FBI <input type="checkbox"/> BIA <input type="checkbox"/> Nat'l Park <input type="checkbox"/> Other _____				Responding Officer or Detective:	
Location of Crime		City	County	State	
Name of Offender(s)		Has arrest been made? <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> Unknown		Charged in Court? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Which Court? <input type="checkbox"/> Municipal <input type="checkbox"/> Justice <input type="checkbox"/> Circuit <input type="checkbox"/> District <input type="checkbox"/> Tribal <input type="checkbox"/> Federal <input type="checkbox"/> Unknown					

Outcome of case? <input type="checkbox"/> Under investigation <input type="checkbox"/> Other <input type="checkbox"/> Prosecution declined <input type="checkbox"/> Conviction <input type="checkbox"/> Unknown	Has restitution been ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Restitution Amount \$
--	--	--------------------------

<b>REQUESTED BENEFITS</b>	<b>Check benefits requested.</b>
---------------------------	----------------------------------

<input type="checkbox"/> Medical/Dental/Counseling	<input type="checkbox"/> Funeral/Burial Expenses	<input type="checkbox"/> Other Economic Expenses
<input type="checkbox"/> Catastrophic Injury	<input type="checkbox"/> Emergency Assistance	<input type="checkbox"/> Loss of Earnings <input type="checkbox"/> Loss of Support

<b>MEDICAL/DENTAL/ COUNSELING EXPENSES/Prescriptions</b>	<b>Attach all itemized bills related to crime. Attach Insurance EOBS.</b>
--	---

Name of Provider (Must Include address/phone number) Attach additional sheets if needed	Amount
	\$
	\$
	\$
	\$

<b>INSURANCE/ OTHER COLLATERAL SOURCES</b>	<b>All bills must be submitted to your insurance carrier or other sources before applying to the compensation program.</b>
--	--

**Was the victim covered by any health insurance or assistance plan at the time of the crime?  Yes  No**

**Carrier/Benefit Plan (Check all that apply)  
Must Include Company Name/Policy number/Policyholder/Address/Phone**

Health Insurance <input type="checkbox"/>	
Medicare/Medicaid/Title 19 <input type="checkbox"/>	
Workers'/Unemployment Comp <input type="checkbox"/>	
Veteran's Administration/Military Insurance <input type="checkbox"/>	
Public Assistance/Welfare/Food Stamps <input type="checkbox"/>	
Accident/Life Insurance <input type="checkbox"/> <b>Must be included if victim is deceased</b>	
Social Security/SSI/SSDI <input type="checkbox"/>	
Indian Health Services <input type="checkbox"/>	
Victim Auto Insurance <input type="checkbox"/> <b>Must be Included if Auto Related Crime</b>	
Offender Auto Insurance <input type="checkbox"/> <b>Must be Included if Auto Related Crime</b>	
Other <input type="checkbox"/>	

<b>FUNERAL/BURIAL EXPENSES</b>	<b>Attach itemized copies of funeral/burial bills. (\$5000.00 Maximum Benefit)</b>
--------------------------------	--

Funeral Home \_\_\_\_\_ Address/Phone number: \_\_\_\_\_  
Other Providers/Expenses (See instructions for eligible expenses):

<b>OTHER ECONOMIC EXPENSES</b>	<b>Attach receipts/bills/estimates for replacement items or clean-up costs. Must claim against insurance first. Check all that apply.</b>
--------------------------------	---

<input type="checkbox"/> Personal Articles Taken As Evidence (\$500 max.) Identify Articles/Estimate Value
<input type="checkbox"/> Homemaker Replacement (Name/Phone # of service provider)
<input type="checkbox"/> Hotel/Rent <input type="checkbox"/> Crime Scene Clean-up (\$500 max.)

Transportation/Mileage  Other Losses:

<b>CATASTROPHIC INJURY</b>	<b>Partial or permanent disability of limbs, sight, hearing, or speech as a direct result of crime. Include receipts/estimates home/vehicle improvements or devices. (\$10,000.00 maximum benefit)</b>
----------------------------	--

Type of disability:	Disability Amount: \$
---------------------	--------------------------

Name of doctor to verify disability:

<b>LOSS OF EARNINGS</b> <b>Victim must be employed at time of crime</b>	<b>Complete if you lost time at work due to a crime. If the victim is employed, include a copy of the most recent federal income tax return</b>
--	---

Was the victim employed at the time of the crime?  Yes  No

Did the victim miss any time from work as a result of the crime?  Yes  No

Has victim returned to work?  Yes  No

Dates absent from work due to crime:    /    /    until    /    /    Hours Missed:

Employer's Name	Contact Person	Phone #
-----------------	----------------	---------

Mailing Address	City	State	Zip
-----------------	------	-------	-----

Did you receive any of the following due to injury/crime? **Sources must be exhausted first.**

Sick Leave    Vacation Pay    Worker's Compensation    Disability    Union Plan    Other

<b>LOSS OF SUPPORT</b> <b>Must be employed at time of crime</b>	<b>This section must be completed when there is loss of support in the event of the death of a victim, or if the offender was a source of support for the family and is no longer contributing.</b>
--	---

Was the  victim or  offender employed at the time of the crime?  Yes  No

Deceased Victim Employer's Name	Contact Person	Phone #
---------------------------------	----------------	---------

Mailing Address	City	State	Zip
-----------------	------	-------	-----

Offender's Employer's Name	Contact Person	Phone #
----------------------------	----------------	---------

Offender's Name	Social Security Number
-----------------	------------------------

Mailing Address	City	State	Zip
-----------------	------	-------	-----

<b>REFERRAL SOURCE</b>	<b>How did you find out about the crime victim compensation program?</b>
------------------------	--

- |  |   |                                       |  |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Victim/Witness Program  | <input type="checkbox"/> Hospital/Doctor      | <input type="checkbox"/> Court System | <input type="checkbox"/> Brochure/Poster |
| <input type="checkbox"/> Family Violence Shelter | <input type="checkbox"/> Funeral Home/Coroner | <input type="checkbox"/> Prosecutor   | <input type="checkbox"/> Relative/Friend |
| <input type="checkbox"/> Law Enforcement         | <input type="checkbox"/> Counselor/Therapist  | <input type="checkbox"/> Probation    | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Attorney                | <input type="checkbox"/> Public Assistance    | <input type="checkbox"/> News/Media   | _____                                    |

Name	Agency	Address	Phone
------	--------	---------	-------

**Before sending this application, make sure to:**

- Sign and date the following authorization page**
- Complete all appropriate sections of the application**
- Attach summary of crime and injuries**
- Attach copies of bills, estimates, and receipts**

**STATEMENT OF UNDERSTANDING**

I understand that 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 that 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 that 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 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.

I understand that 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/We hereby agree to repay 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 that 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 that 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 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 also understand that the limitations of this agreement in no way limits the Division's ability to pursue its own revenue recovery to the extent that 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, that 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 that 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.)**

\_\_\_\_\_  
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, 122 W. 25<sup>th</sup>, Herschler Bldg. 1<sup>st</sup> Floor West, Cheyenne, WY 82002.  
For assistance with completing this application, call toll- free at 1-888-996-8816.  
Revised 03/2005**

**THIS PAGE MUST BE COMPLETED AND SIGNED**

RETURN TO:  
DIVISION OF VICTIM SERVICES  
122 W 25<sup>TH</sup>, 1<sup>ST</sup> FLOOR WEST  
CHEYENNE, WY 82002  
(307) 777-7200  
FAX (307) 777-6683

WOLFS-109 REVISED 11/2002  
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 BENEFITS,  
THIS FORM MUST BE COMPLETED AND SIGNED!**

