

DIVISION OF VICTIMS SERVICES

ASSOCIATED VICTIM ELIGIBILITY

(formerly “Secondary Victim” Eligibility)

An authorization form shall be signed by associated victims so that they are under the same legal obligation as primary victims and understand their commitment once they have accepted victim aid. As with the primary victim, all collateral resources should be identified and assessed before applying for victim’s compensation.

If claimants are going to seek associated victim benefits (formerly “secondary victim benefits”), they do not need to complete a separate application. If the associated victims are people other than the claimant, then they must complete the Associated Victim Application.

With respect to caps and priorities, the primary victim has first rights and if the primary victim’s bills are above \$15,000 (7/1/99), there are no funds remaining for the secondary victims.

Who is eligible?

- Children who witness violent crimes against adults
- Spouses residing with sexual assault victims
- Household members (as defined in W.S.9-1-637(d)(vi)) of minor victims*
- Household members (as defined in W.S.9-1-637(d)(vi)) of homicide victims*

* “House member” means:

- (a) persons married to each other
- (b) persons living with each other
- (c) persons formerly married to each other
- (d) persons formerly living with each other as if married
- (e) parents and their adult children
- (f) other adults sharing common living quarters
- (g) persons who are the parents of a child but who are not living with each other

What expenses are eligible?

Associated victims may be eligible for compensation with regard to counseling and other economic losses. The compensation paid to an associated victim is included in the primary victim’s cap of \$15,000 (7/1/99).

Counseling: There is a **\$1,500 cap** for counseling for each associated victim.

Other Economic Losses: Other economic losses include, but are not limited to, mileage, food, lodging, and loss of earnings. These out of pocket expenses may be reimbursed if they were incurred by the associated victim, due to the death or injury of the primary victim. As with the primary victim other collateral resources must be exhausted first.

Example

Examples of Associated Claims:

Debbie Jones is a six-year-old victim of sexual assault. Debbie is the victim. Mrs. Jones, Debbie’s mother, is the claimant and is also an associated victim. Mrs. Jones is seeking financial assistance for transporting Debbie from Douglas to Casper for weekly therapy sessions. Since Mrs. Jones is the claimant, she does not need to complete a separate application. Debbie’s eight-year-old sister, Julie, is in need of counseling due to this crime. She is also an associated victim, but because she is not the claimant she must complete a separate associated victim application.

Examples of Claimants:

Survivors of a homicide
Parents of minor children
Caretakers of incompetent victims

Examples of Associated Victims, but not Claimants:

Siblings or other household members
Children who witness a violent crime being committed against an adult

**To obtain an Associated Victim Application, contact
the Division of Victim Services at (307) 777-7200 or the local program in your county.**

STATE OF WYOMING
 DIVISION OF VICTIM SERVICES - COMPENSATION PROGRAM
 ASSOCIATED VICTIM APPLICATION
 122 W. 25, Herschler Bldg. 1st Flr. West
 Cheyenne, WY 82002
 (307) 777-7200
 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 victim's 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"/> Employee Assistance Program				
<input type="checkbox"/> Medicare		<input type="checkbox"/> Other (explain) _____				
<input type="checkbox"/> Medicaid		<input type="checkbox"/> None				
<input type="checkbox"/> Veteran's Benefits						
If any of the above resources are checked, please give company name, address & policy number(s) 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 photocopy 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 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