Submission from State of Iowa Office of the Attorney General (Online Crime Victim Compensation Application)

State of Iowa Office of the Attorney General <webteam@feedback.iowa.gov>
Tue 10/25/2022 11:08 AM

To: Wilson, Sondra <adwilson8@dmacc.edu>

Thank you for contacting us. Your request has been submitted.

Crime Victim's Information

Full name of the person completing this form:	Alexandra Distance Marie Wilson
Contact email address:	adwilson8@dmacc.edu
Type of Crime:	fraud and legal assault
I am the:	Victim of the crime.
First Name:	Alexandra
Last Name:	Wilson
Applicant Mailing Address:	4733 Toronto St. #112
Applicant City:	Ames
Applicant State:	IA
Applicant Zip Code:	50014
Applicant Phone Number:	515-357-9725
Date of birth:	01/26/1982
Social Security Number (submitted information is secure and encrypted):	**********
Primary Language:	English
Preferred method of contact (we must be able to reach you for more information):	Email

Criminal Report and Investigation Information

City or location of crime:	Ames
Victim's injuries:	Continuing injury to my reputation as a result of malicious character assassination and actual fraud against me. Severe mental and emotional distress and lack of sleep as a result of fear induced from threats, triggering of mental health conditions including symptoms of PTSD. Fear for my physical safety, fear for my reputation, and fear for my work and business's reputations.

Irreparable injuries and reparable injuries.

Date of crime:	03/31/2022
Crime discovery date:	08/03/2022
Was the crime reported?:	Yes
Crime report date:	10/24/2022
Investigating agency:	Iowa Civil Rights Commission and Ames Police Department
Investigating law enforcement agency case number:	CP-04--22-7265 and Ames PD said contact other agencies
Name of investigating officer:	Uvaldo (ICRC), Officer Sheefer (Ames)
Is your alleged offender a law enforcement officer?:	No
Offender's Name:	Lyndsay Nissen
Offender's Name:	Charlie Esker
Offender's Name:	Jane Does
Was a sexual assault examination performed?:	No

If the offender has been arrested and is still in custody, you can register to receive notifications of when he/she is released from jail or transfers within the jail/prison system. For more information about IowaVINE, click here. To register for notifications click here to go to the VINELink website.

Was the crime related to (select any that applies):	Bullying,Hate crime

Crime-Related Expenses

Crime-Related Expenses:	Victim's medical or dental expenses,Transportation/mileage expenses,Victim's counseling expenses

Medical or dental expenses

Medical Provider Name:	Mary Greeley Medical Center
Medical Provider Address:	1111 DuffAve, Ames, IA 50010
Medical Provider Phone:	515-239-2011

Counseling Expenses

Mental Health Provider Name:	Eyerly-Ball
Mental Health Provider Address:	2521 S University Blvd UNIT 121, Ames, IA 50010

Mental Health Provider Phone:	515-598-3300
Mental Health Provider Name:	DMACC
Mental Health Provider Address:	1125 Hancock Dr, Boone, IA 50036
Mental Health Provider Phone:	800-362-2127
Crime-related expenses of a homicide victim's survivor:	none
Does the crime victim have minor children or other financial dependents?:	No

Insurance and Attorney Information

Insurance Types:	Health insurance,Medicaid or Medicare
Health Insurance Company Name:	Amerigroup
Health Insurance Company Address:	4800 Westown Pkwy, West Des Moines, IA 50266
Health Insurance Policy Number:	2235184H
Medicare or Medicaid Company Name:	Amerigroup
Medicare or Medicaid Company Address:	4800 Westown Pkwy, West Des Moines, IA 50266
Medicare or Medicaid Policy Number:	483-13-3852
Attorney Information:	I do not have an attorney

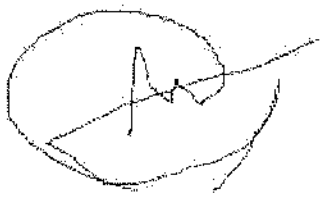
Demographic Information

Age:	25-59
Gender:	Female
Do you have a disability?:	Yes
Ethnicity:	White
Referred to Program by:	Police/sheriff,Other
Specify Referral:	Bruce Lasch, Boone DMACC Security

Repayment and Subrogation Agreement

- I understand that Iowa law requires me to repay the Crime Victim Compensation Program (CVC) if I receive any payment from the offender, a civil lawsuit, an insurance program, or another government or private agency after I receive payment from CVC for the same expenses.
- I also agree to notify the CVC if I have an attorney represent me in any action related to this crime. I certify the information in this application is true and correct to the best of my knowledge. I understand that with my signature I agree to all statements in this agreement.
- **Parent or guardian must sign if victim is a minor or dependent adult**; applicant must sign if the victim is deceased. **If the victim is an adult and not completing the application, the victim must sign the release.**

Signature Repayment Agreement: Alexandra Wilson



Today's Date Repayment Agreement: 10/25/2022

Health Care Information Release

Victims Medical and Dental expenses:

Medical Provider Name:	Mary Greeley Medical Center
Medical Provider Address:	1111 DuffAve, Ames, IA 50010
Medical Provider Phone:	515-239-2011

I give permission to any hospital, clinic, doctor, insurance company, employer, person, funeral home, victim service provider to verify crime details, or agency, including the University of Iowa Hospitals and Clinics, to give requested information, including medical records and test results which may include drug and alcohol and HIV & AIDS screening and related information to the CVC Program of the Iowa Department of Justice. This release does not authorize records protected under 42 CFR, Iowa Code Chapter 228 or Iowa Code section 141A.9. This authorization is valid for information already in existence and information generated while the authorization is in effect.

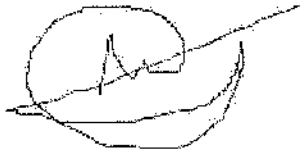
I understand that:

- The CVC Program will request only information needed to determine benefits for which I am eligible;
- Iowa and federal law requires the CVC Program to keep confidential all confidential information received;
- This information release is valid for one year from the date of my signature;
- I can cancel the release by writing to the CVC Program at any time; except where the information has already been received and used, then it is not subject to cancellation;
- A photocopy of this signed form is as valid as the original; and
- My signature gives permission for the release of all information specified in this permission form. (**Parent or guardian must sign if victim is a minor or dependent adult**; applicant must sign if the victim is deceased. **If the victim is an adult and not completing the application, the victim must sign the release.**)

Disclosure Notice: Federal and State laws specifically require that any disclosure or re-disclosure of mental health, drug/alcohol, HIV screening and AIDS-related information must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless disclosure

is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient. (See also Iowa Code Chapter 228 and section 141A.9 and applicable laws.)

Signature Release of Info: Alexandra Wilson



Today's Date Release of Info: 10/25/2022

Mental Health Special Medical Information Release

Victims counseling expenses:

Mental Health Provider Name:	Eyerly-Ball
Mental Health Provider Address:	2521 S University Blvd UNIT 121, Ames, IA 50010
Mental Health Provider Phone:	515-598-3300

Mental Health Provider Name:	DMACC
Mental Health Provider Address:	1125 Hancock Dr, Boone, IA 50036
Mental Health Provider Phone:	800-362-2127

The CVC will keep confidential all mental health counseling, drug or alcohol treatment, HIV and AIDS screening and related information, including counseling notes.

Disclosure Notice: Federal and State laws specifically require that any disclosure or re-disclosure of mental health, drug/alcohol, HIV screening and AIDS-related information must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient. (See also Iowa Code Chapter 228 and section 141A.9 and applicable laws.)

I specifically authorize any hospital, clinic, doctor, insurance company, agency or mental health provider, including the University of Iowa Hospitals and Clinics, to release information to the CVC Program of the Iowa Department of Justice. I specifically authorize disclosure and re-disclosure of this information as provided in section 3 of this form. This authorization is valid for information already in existence and any information generated while authorization is in effect.

I understand that:

- The CVC Program will request only information needed to determine about CVC benefits for which I am eligible;
- This information release is valid for one year from the date of my signature;

- I can cancel the release by writing to the CVC Program at any time; except where the information has already been received and used, then it is not subject to cancellation;
- I have a right to inspect the disclosed mental health information at any time by contacting the mental health provider who has the records;
- A photocopy of this signed form is as valid as the original; and
- My signature gives permission for the release of all information specified in this permission form. (**Parent or guardian must sign if victim is a minor or dependent adult**; applicant must sign if the victim is deceased. **If the victim is an adult and <u>not</u> completing the application, the victim must sign the release.**

Signature Mental Health Release: Alexandra Wilson

Today's Date Mental Health Release: 10/25/2022

**********; Encrypted Data