CALIFORNIA CalVCB VICTIM COMPENSATION BOARD

Associated Application ID (Enter if known)

Application For Good Samaritan Compensation

Section 1: Claimant

A separate application must be filed for each person seeking assistance.
Section 1 must be completed for all applications. The Good Samaritan claimant is the person who has expenses or is seeking assistance as a result of a crime. If you are filing this application on behalf of someone else, put their information in Section 1 and your information in Section 3.

Preferred Spoken Language

Preferred Written Language

First Name | Middle Name | Last Name | Gender

Relationship to Victim | Social Security Number (SSN) | No SSN | Date of Birth

Mailing Address

Street Number and Name or PO Box

From the date of the crime to now, has the **claimant** been in prison, on probation, on parole or post-release community supervision because of a felony?

Is the **claimant** required to register as a sex offender?

Address 2 (Apartment or Unit #) | City | State (CA) | Zip | Home Telephone

Work Telephone | Extension | Cell Phone | E-mail | E-mail Type

If you are an adult victim and the expenses are for you, skip to Section 4.

If not, continue to Section 2.

Section 2: Good Samaritan

The Good Samaritan is the private citizen who incurs personal injury or death or damage to his or her property.

First Name | Middle Name | Last Name | Gender

Social Security Number (SSN) | No SSN | Date of Birth | If victim is deceased, date of death

Mailing Address

Street Number and Name or PO Box

From the date of the crime to now, has the **Samaritan** been in prison, on probation, on parole or post-release community supervision because of a felony?

Is the **Samaritan** required to register as a sex offender?

Address 2 (Apartment or Unit #) | City | State (CA) | Zip | Home Telephone

Work Telephone | Extension | Cell Phone | E-mail | E-mail Type

If you are completing this application on behalf of a minor or an incapacitated adult, continue to Section 3.
If not, skip to Section 4.

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Section 3: Parent or Guardian (Applicant)

This section is for parents or guardians of minors or incapacitated adults in Section 1.

Please indicate your relationship to the person listed in Section 1:

First Name | Middle Name | Last Name | Gender

Social Security Number (SSN) | No SSN | Date of Birth

Mailing Address

Street Number and Name or PO Box

From the date of the crime to now, have **you** been in prison, on probation, on parole or post-release community supervision because of a felony?

Are **you** required to register as a sex offender?

Address 2 (Apartment or Unit #) | City | State (CA) | Zip | Home Telephone

Work Telephone | Extension | Cell Phone | E-mail | E-mail Type (Personal)

Continue to Section 4.

Section 4: Information About Your Expenses

For the victim of the crime, the following benefits may be available. Please check the crime-related expenses you are requesting. Please attach copies, or a list, of any crime-related bills.

- ☐ Medical and/or dental expenses
- ☐ Mental health treatment
- ☐ Income loss (if you missed work because of the crime)
- ☐ Moving or relocation expenses
- ☐ Funeral/burial
- ☐ Home or vehicle modifications
- ☐ Property loss

Other crime-related expenses

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Section 5: Crime Information

Law Enforcement Agency Name

If reported to law enforcement, name of the law enforcement agency

Dates Crime Occurred

From

If on one day, enter only From.

To

Date Crime was Reported

Crime Report Number

Describe Injuries

Location of Crime (if known)

Address, Intersection, Area, etc.

Person who committed the crime (suspect), if known

☐ Suspect unknown

First Name

Middle Name

Last Name

Address 2 (Ste. #)

City

State

CA

Zip

County

Type of Crime

Describe your actions to prevent the crime,apprehend a criminal, or rescue a person in immediate danger of injury or death as a result of fire, drowning, or other catastrophe.

Note: A corroborating statement and recommendation from the appropriate state or local public safety or law enforcement agency must be attached to this application.

Section 6: Representative Information (A representative is not needed to apply for victim compensation.)

This section is for representatives only. Victim Witness Assistance Center Advocates need only provide phone, name, center #, sign and date. All other representatives, please fill out this section completely.

Please indicate your relationship to the person listed in Section 1:

If other, please indicate:

First Name

Middle Name

Last Name

Telephone

Extension

Organization Name

Mailing Address

Street Number and Name or PO Box

Address 2 (Suite #)

For Attorneys Only

☐ I am requesting payment pursuant to Government Code Section 13957.7(g).

Tax ID

City

State

CA

Zip

State Bar Number

Telephone

E-mail

For Victim Assistance Center Staff Only

JP/VWC Number

Signature and Date Required for all Representatives

Representative's Signature

Date

Section 7: How Did You Find Out About the Board?

☐ Law Enforcement ☐ District Attorney ☐ Medical Provider ☐ Children's Protective Services

☐ Adult Protective Services ☐ Mental Health Provider ☐ Victim Witness Assistance Center ☐ Media (TV, Radio, Newspaper, etc.)

☐ Billboard or Poster ☐ Card or Booklet ☐ Other

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Section 8: Federal Reporting Information

The following **voluntary** information is for the person receiving compensation and is used for statistical purposes only to comply with federal regulations.

Ethnicity

☐ American Indian/ Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Native Hawaiian and Other Pacific Islander ☐ White Non-Latino/ Caucasian

☐ Multiple Races ☐ Decline to State ☐ Other Race

Is the victim disabled? ☐

Was the victim disabled prior to the crime? ☐

Section 9: Insurance Information

Please list your insurance information below. The California Victim Compensation Board (CalVCB) is the payor of last resort. We may contact your insurance company as a potential reimbursement source.

☐ I have no insurance of any kind.

Health Insurance

Medi-Cal Benefits Identification Card Number

Issue Date

Health Insurance Company Name

Policy Number

Group Number

Telephone

Ext.

Mailing Address

Street Number and Name or PO Box

Address 2 (Suite #)

City

State CA

Zip

Name of Insured

First Name

Middle Name

Last Name

Have you filed an insurance claim related to this crime?

Auto/Vehicle Insurance (Includes car, truck, motorcycle, motorhome, boat, jet ski, airplane, etc.)

Complete if the crime involves a vehicle, including pedestrians hit by a vehicle.

Auto Insurance Company Name

Policy Number

Telephone

Ext.

Mailing Address

Street Number and Name or PO Box

Address 2 (Suite #)

City

State CA

Zip

Name of Insured

First Name

Middle Name

Last Name

Have you filed an insurance claim related to this crime?

Other Insurance

Please check any additional insurance sources that could be applied to your application.

☐ Medi-Cal ☐ Medicare ☐ Workers' Comp ☐ Other

If you have more than one insurance provider, please list on a separate piece of paper and mail with your application.

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Section 10: Employer Information

Please list the Good Samaritan's employer. If you are a parent/guardian seeking wage loss benefits because a minor Good Samaritan was hospitalized or is deceased, list your employer.

Contact Person

Employer's Business Name	First Name	Last Name	Telephone	Ext.	OK to contact employer?

Mailing Address

Street Number and Name or PO Box	Address 2 (Suite #)	City	State	Zip
			CA	

Is or was the Good Samaritan self-employed? ☐

Did the Good Samaritan miss work as a result of crime-related injuries? ☐

Did the crime occur while the Good Samaritan was on the job or at the workplace? ☐

If you have more than one employer, please list on a separate piece of paper and mail with your application.

Section 11: Civil Suit Information

If you decide to file a civil suit, by law, you are required to notify CalVCB within 30 days of filing the action.

Have you filed, or do you plan to file, a civil suit related to this crime? ☐

Attorney's Name

First Name	Middle Name	Last Name	Telephone	Extension

Mailing Address

Street Number and Name or PO Box	Address 2 (Suite #)	City	State	Zip
			CA	

Your application for crime victim compensation is almost complete.

- After entering all available information, print the application.
- Attach copies of any documentation that supports your application for Good Samaritan compensation, including copies of crime-related bills, insurance, or anything relating to the crime. Save original documents for your records.
- Please read the next page carefully, sign and date, and send to the address indicated or deliver to your local Victim Witness Assistance Center.
- CalVCB will send you a letter acknowledging that your application has been received. The acknowledgment letter will include additional information about the benefits requested on your application.
- A CalVCB representative may contact you for additional information if you were not able to provide it with your application.
- For any questions about victim compensation, you can contact your local Victim Witness Assistance Center or call CalVCB at 1-800-777-9229.

This page **must** be signed and dated.

Section 12: Information Release

I give permission to any healthcare provider; any medical biller, any funeral director or similar persons, any employer, any police or other government agency, including the Department of Justice, the Social Security Administration, the State Franchise Tax Board, and the Federal Internal Revenue Service; any insurance company; or any other person or agency, to provide information relating to this application, including medical (including, but not limited to history or physical records, consultation reports, pathology reports, discharge summaries, operative reports, X ray and other radiology reports, laboratory reports, chart notes, narrative reports, and billing records), mental health, and felony conviction records, to the California Victim Compensation Board (CalVCB) or its representatives, for the purpose of determining eligibility for CalVCB benefits. This permission also applies to all sources of recovery for the claimed losses, including but not limited to, health or medical benefits, unemployment or disability benefits, Social Security benefits (Social Security disability, Supplemental Security income, and/or retirement, including the supporting medical and/or mental health records), and Veteran benefits. I also give permission for the release of federal and state tax information, including tax returns, for the purpose of verifying income. I hereby waive all legal privileges to any of this information required by CalVCB regarding my claim.

I agree that a photocopy or fax of this signed form is as valid as the original, and my signature gives permission for the release of all specified information.

I agree that CalVCB or its representatives may pursue restitution from the convicted offender in this matter to recover monies paid to me by CalVCB and that by filing this application I have authorized use of information in this application and subsequent claim files to pursue restitution from the convicted offender.

In order to verify or process this application, I agree that CalVCB or its representatives may provide information about this application, and the information contained in this application, to any representative named on this application, government agency, or health care provider or other provider of services, and may pay the provider directly if payment of these services is approved.

I agree that I may revoke this authorization at any time. The revocation must be in writing. The revocation will take effect when CalVCB receives it, but I may be deemed ineligible for CalVCB benefits once the revocation is received by CalVCB. However, no healthcare provider may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I am entitled to a copy of this authorization except in limited circumstances. I agree that information disclosed under this authorization may be redisclosed by the recipient as required by law and this redisclosure may no longer be protected by federal or state law.

I agree that the authorizations and agreements herein will expire ten (10) years after the date of my signing this form.

Signed	Date

(Parent or guardian must sign if victim is a minor or incapacitated.)

Section 13: My Agreement to the California Victim Compensation Board

As required by California law, I will contact and repay the California Victim Compensation Board (CalVCB) if I, or anyone on my behalf, receives any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private entity, for losses suffered as a direct result of the crime that was the basis for receipt of benefits from CalVCB, in the amount of the total benefits granted by CalVCB. I understand I may be responsible for repaying CalVCB any amount for which it is later determined that I was not eligible. I will notify CalVCB if I hire an attorney to represent me in any action related to this crime or if I pursue any action on my own.

Any monies I receive from CalVCB for moving/relocation expenses, improving home security, or for modifying a home or vehicle for a disabled victim will be used only for those purposes. If I am a victim of domestic violence receiving moving/relocation expenses, I will not tell the offender my home address nor allow the offender on the premises at any time, or I will seek a restraining order against the offender.

In the event that I am compensated for any pecuniary loss by CalVCB and the State of California subsequently receives compensation for the same loss on my behalf from the perpetrator (including any monies received through a restitution order) or from any other source, I hereby assign to the Victim Compensation Board any and all rights to such duplicate compensation.

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct and completed to the best of my knowledge and belief. I understand that I may be found to be ineligible for benefits, and that action may be taken to recover benefits I receive if I provide information that is false, intentionally incomplete, or misleading.

Signed	Date

(Parent or guardian must sign if victim is a minor or incapacitated. County social workers, see section 13a.)

Printed Name

Section 13a: For County Social Workers Only

As required by California law, I will contact and inform the California Victim Compensation Board (CalVCB) if I learn the claimant receives any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private entity, for losses suffered as a direct result of the crime that was the basis for receipt of benefits from CalVCB.

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct and completed to the best of my knowledge and belief. I understand that the claimant may be found to be ineligible for benefits, and that action may be taken to recover benefits the claimant receives if the claimant provides information that is false, intentionally incomplete, or misleading.

Signed	Date
Printed Name	

Mail completed application to:

California Victim Compensation Board
PO Box 3036, Sacramento, CA 95812-3036

or

deliver to your local Victim Witness Assistance Center

For more information call:

1-800-777-9229

Hearing impaired, please call the California Relay Service (711)

victims.ca.gov *Helping California Crime Victims Since 1965*

Privacy Notice on Collection

1. CalVCB collects this information based on California Government Code sections 13952 et seq. and 13954.
2. All information collected from this site is subject to, but not limited to, the Information Practices Act. See http://victims.ca.gov/media/pra.aspx.
3. This information is collected for the purpose of determining eligibility for compensation.
4. CalVCB may disclose your personal information to another requestor, only if required to do so by law or in good faith that such action is necessary to:
   a. Conform to the edicts of the law or comply with legal process served on CalVCB or the site;
   b. Protect and defend the rights or property of CalVCB; and,
   c. Act under exigent circumstances to protect the personal safety of users of CalVCB, or the public.
5. Individuals are to provide only the information requested.
6. The information provided is mandatory.
7. The consequences of not providing the requested information could result in the denial of your application.
8. You have the right to access the records containing the personal information that you provided.
9. The information collected is used by the California Victim Compensation Program.
10. Any questions regarding the information collected, please write to the following address: PO Box 48, Sacramento, CA 95812, email info@victims.ca.gov, call (800) 777-9229, or contact the CalVCB Privacy Coordinator at InfoSecurityandPrivacy@victims.ca.gov.
11. For additional information regarding privacy, please see CalVCB's Privacy Notice. See http://victims.ca.gov/privacy.aspx.
12. For information regarding consumer information on security, please visit https://oag.ca.gov/privacy/online-privacy.