Representative Request Form

CalVCB App ID:_____ **Claimant Name:**_____

Written consent is required to authorize any individual as a representative on your CalVCB application. A medical or mental health provider, or their agent, who has provided services to you is not eligible to be an authorized representative.

This consent authorizes an individual of your choosing to assist you with the following necessary responsibilities associated with filing and processing your application and expenses including, but not limited to:

- Completion of the CalVCB application
- Obtain and submit crime related documentation, such as medical records
- File an appeal on behalf of the applicant
- Receive, review, and respond to all correspondence
- Provide status updates on the claim, such as reimbursement timeframes
- Provide guidance on how the compensation benefits are to be applied

I authorize the following individual to be the representative on my application.

Representative Information		
First Name:	Middle Name:	Last Name:
Phone Number:	Fax Number:	
Mailing Address:		
Relationship to Applicant: (Choose one) ☐ Attorney ☐ Friend ☐ Community-based Advocate ☐ Spouse ☐ Parent ☐ Family Member ☐ Victim Witness Advocate (JP/VWC #):_____ ☐ Other: (Describe) _____		
For Attorneys Only		
CalVCB requires attorney representatives to provide an Attorney Fee Service Form available online at https://victims.ca.gov/publications/calvcpforms.aspx		
Agency Name:		
Tax ID:	State Bar Number:	
Email Address:		
Are you requesting payment pursuant to Government Code Section 13957.7(g)? ☐ Yes ☐ No		

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The information shared may be via verbal communication, written documentation, and/or electronic transmission (email/fax).

I understand that this release is valid when I sign it, and that I may withdraw my consent to this release at any time either verbally or in writing.

For dependent minors or adults, the parent or legal guardian must provide his/her signature consenting for the dependent to allow the chosen individual as a representative on the CalVCB claim.

Applicant Signature	Date	Representative Signature	Date
Applicant Print Name		Representative Print Name	

Please mail or fax this Consent Form to:

CALIFORNIA VICTIM COMPENSATION BOARD
P O Box 3036 • Sacramento, California 95812-3036
Fax: 1-866-902-8669