Medical or Mental Health Provider Relocation Verification Form

CalVCB Application No.: _____

Instructions: A statement from the medical or mental health treatment provider is required when a victim of a qualifying crime is requesting relocation benefits from the California Victim Compensation Board (CalVCB) due to crime related emotional trauma. The victim's medical or mental health provider must complete the following information or submit a letter to CalVCB on a prescription pad or letterhead stationery that contains all the information requested in this form including signature and license number. See victims.ca.gov for more details.

Victim Information

Name		Phone Number	
Address	City	State	Zip

Crime Information

Crime Date	Type of Crime

Is need to relocate directly related to the qualifying crime? ☐ **Yes** ☐ **No**

Did the qualifying crime result in permanent and substantial disability of the victim? ☐ **Yes** ☐ **No**

Did victim testify or is victim scheduled to testify as a witness in criminal proceedings related to the qualifying crime and need to relocate is necessary as a result of testifying? ☐ **Yes** ☐ **No**

Did the qualifying crime result in substantial impairment of the victim's Activities of Daily Living? ☐ **Yes** ☐ **No**

Explain why relocation is necessary for the victim's **emotional well-being**. If the victim's Activities of Daily Living have been substantially impaired, please explain:

Medical or Mental Health Provider Information

Medical or Mental Health Provider Name	Phone Number
Provider/Organization Address	
Medical or Mental Health Signature	Date
License Number	Expiration Date

***Important Note for Supervised Mental Health Providers!:** *Psychology Intern, Psychological Assistant, Associate Social Worker, or Sexual Assault Counselor requires a signature from the licensed supervising therapist.*

*Licensed Supervising Therapist Name	*Signature	*Phone Number
*License Number		*Expiration Date

FOR STAFF USE: If Form is not fully completed by the treating medical or mental health provider, contact the provider, add the missing information, complete the section below and have the document scanned in.

Medical or Mental Health Provider Supplying Information	Phone Number	
VW Center Name, Number and Advocate/ Staff Completing This Form	Phone Number	Date