STATE OF CALIFORNIA

Forced or Involuntary Sterilization Compensation Program Application

VCB–31–10002a (Rev. 04/2022)

CALIFORNIA CalVCB VICTIM COMPENSATION BOARD

***Required**

Section 1: Claimant and Representative Information

Preferred Language

*Spoken: _____ *Written: _____

Claimant Information *(individual subjected to forced or involuntary sterilization)*

*Full Legal Name: _____
First, Middle, Last

*Mailing Address: _____
Street Number and Name or P.O. Box

_____
Address 2 (Apartment or Unit #)

_____
City, State, ZIP

*Date of Birth: _____
MM / DD / YYYY

*SSN: _____

☐ No Social Security Number

Phone: _____ Email: _____

Is the claimant currently in the custody of the Department of Corrections and Rehabilitation (CDCR)?

☐ No ☐ Yes. If yes, provide the claimant's full name *(if different than above)* along with CDCR identification number, housing unit and cell number.

Full Name: _____
First, Middle, Last

CDCR Number: _____

Housing Unit: _____ Cell Number: _____

Legally Authorized Representative of the Claimant *(if applicable)*

If a Legally Authorized Representative is submitting this application on behalf of the claimant, the representative must complete the entire section below and attach proof of designation.

Full Name: _____
First, Middle, Last

Agency Name *(if applicable)*: _____

Type of Agency *(if applicable)*: _____ Relationship to the Claimant: _____

Mailing Address: _____
Street Number and Name or P.O. Box

_____
Address 2 (Apartment or Unit #)

_____
City, State, ZIP

Phone: _____ Email: _____

Section 2: Sterilization Procedure Details

Please complete this information to the best of your knowledge.

The claimant was sterilized, or suspects sterilization

☐ As a resident of, or at, a state hospital, home or institution run by the California Department of State Hospitals or the California Department of Developmental Services.

Facility Name: _____

☐ While in custody at a state prison or other correctional facility run by the California Department of Corrections and Rehabilitation.

Facility Name: _____

☐ Other *(please specify)*: _____

Claimant name at time of the sterilization, or suspected sterilization

Full Name: _____

Maiden, Alias or Other Name(s): _____

Facility Name Where Sterilization Procedure Occurred *(if different from above)*:

_____ ☐ Unsure of Facility Name

Date of Sterilization: _____ *MM/DD/YYYY* Age at Time of Sterilization: _____

Sterilization Procedure/Type: _____

Section 3: Trust or Beneficiary Designation

If the claimant wishes to identify a trust or designate a beneficiary, please complete this section. If not, please proceed to Section 4.

☐ **TRUST DESIGNATION:** A claimant may assign compensation to a trust established for the claimant's benefit. This entire section must be completed and the fully executed trust must be submitted for the compensation to be paid to the trust.

Full Legal Name of Trust: _____ Date of Trust: _____ *MM/DD/YYYY*

Tax Identification Number: _____

Name of Trustee(s): _____

_____

Mailing Address: _____
Street Number and Name or P.O. Box

_____
Address 2 (Apartment or Unit #)

_____
City, State, ZIP

Phone: _____ Email: _____

☐ **BENEFICIARY DESIGNATION:** A claimant may designate a beneficiary to receive the claimant's compensation. All beneficiary information must be completed in order for compensation to be paid to the beneficiary in the event of the death of a qualified claimant.

Full Legal Name of Beneficiary: _____ Date of Birth: _____
First, Middle, Last *MM/DD/YYYY*

Social Security Number: _____ Relationship: _____

Mailing Address: _____
Street Number and Name or P.O. Box

_____
Address 2 (Apartment or Unit #)

_____
City, State, ZIP

Phone: _____ Email: _____

Section 4: Supporting Documents

☐ **Check box if supporting documents are included with this application.**

Documentation may include, but is not limited to:

- Documentation of the sterilization
- Sterilization recommendation
- Surgical consent forms
- Relevant court or institutional records
- A signed statement by the claimant, claimant's physician, or another individual with knowledge of the sterilization
- Any other documentation that will support the application

Section 5: Voluntary Demographic Information

The following voluntary information is used for statistical purposes to comply with state statute. If you choose not to provide this information, please proceed to Section 6.

Claimant's Current Age: _____

☐ Check box if claimant is a person with a disability.

Ethnicity *(check only one)*

☐ Hispanic, Latino or Spanish origin ☐ Not Hispanic, Latino or Spanish origin

Race *(check one or more)*

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Chinese ☐ Chamorro ☐ Filipino ☐ Indian ☐ Japanese
☐ Korean ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White
☐ Other Asian or Pacific Islander *(please specify)*: _____
☐ Other *(please specify)*: _____

Gender

☐ Female ☐ Male ☐ Transgender

☐ Other *(please specify)*: _____

Sexual Orientation

☐ Straight ☐ Gay or Lesbian ☐ Bisexual

☐ Other *(please specify)*: _____

Section 6: Voluntary Outreach Information

The following voluntary information is used for statistical purposes and to evaluate the effectiveness of outreach efforts. If you choose not to provide this information, please proceed to Section 7.

How did you hear about this program?

☐ Department of Corrections and Rehabilitation
☐ Law Enforcement
☐ Medical Provider
☐ Mental Health Provider
☐ Parole or Probation Office
☐ Social Media
☐ Victim Compensation Board
☐ Other Media (News reports, radio, etc.)
☐ Community-Based Organization
☐ Other *(please specify)*: _____

*Section 7: California Payee Data Record Form (STD. 204)

This form is required for any individual entering into a transaction that may lead to a payment from the state.

☐ *California Payee Data Record form (STD. 204) is included with this application.

*Section 8: Information Release, Compensation Agreement and Signature

Please read the next page carefully, sign and date, and mail, email or fax to the address indicated. CalVCB will mail you a letter acknowledging that your application has been received. A CalVCB representative will contact you for additional information, if needed, to complete the processing of your application.

I give permission to any government agency, including the California Department of State Hospitals, California Department of Developmental Services, Federal Receiver, California Correctional Health Care Services, California Department of Corrections and Rehabilitation and all of their facilities or institutions, or any other person or agency, to provide information relating to this application, including medical documentation, and also 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 or narrative reports to the California Victim Compensation Board (CalVCB) or its representatives, for the purpose of determining eligibility for CalVCB compensation. I hereby waive all legal privileges to any of this information acquired by CalVCB regarding my claim.

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

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.

I understand and acknowledge 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 compensation through the CalVCB Forced or Involuntary Sterilization Compensation Program once the revocation is received by CalVCB. 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 with the expiration of the Forced or Involuntary Sterilization Compensation Program.

I understand that if I die during the pendency of the application, or before the board determines that I am a qualified recipient, and I do not name a trust or beneficiary, the eligible recipient compensation shall remain with the board for expenditure in accordance with subdivision (b) of Section 24213 of the California Health and Safety code.

Claimant

*Printed Name: _____
First, Middle, Last

*Signature: _____ *Date: _____
MM/DD/YYYY

Authorized Legal Representative *(if applicable)*:

Printed Name: _____
First, Middle, Last

Signature: _____ Date: _____
MM/DD/YYYY

Mail, email or fax completed form to:

California Victim Compensation Board
c/o Forced or Involuntary Sterilization Compensation Program
P.O. Box 591
Sacramento, CA 95812-0591
Email: FISCP@victims.ca.gov
Fax: 916-491-6429

For more information:

1-800-777-9229 | Hearing impaired, call the California Relay Service (711)