STATE OF CALIFORNIA

APPLICATION FOR GOOD SAMARITAN COMPENSATION

VCB-31-10014 (Rev. 05/2022)

Section 1: Good Samaritan Claimant

This section must be completed for all applications. The Good Samaritan Claimant is the private citizen who incurs personal injury or death or damage to his or her property. If you are filing this application on behalf of a minor or incapacitated adult, put their information in Section 1 and your information in Section 2.

Preferred Spoken Language: _____ Preferred Written Language: _____

First Name: _____ Middle Name: _____

Last Name: _____ Gender: _____

SSN: _____ ☐ No SSN Date of Birth: _____

Home Telephone: _____ Cell Phone: _____

Email: _____

Mailing Address

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

Address 2 *(Apartment or Unit #)*: _____

City: _____ State: _____ Zip: _____

If you are completing this application on behalf of a minor or an incapacitated adult, continue to Section 2.

If not, skip to Section 3.

Section 2: 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: _____

SSN: _____ ☐ No SSN Date of Birth: _____

Home Telephone: _____ Cell Phone: _____

Email: _____

Mailing Address

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

Address 2 *(Apartment or Unit #)*: _____

City: _____ State: _____ Zip: _____

Continue to Section 3.

Section 3: Information About Your Expenses

The following benefits may be available. Please check the expenses you are requesting and attach copies or estimates of any incident-related bills. All actual or estimated expenses must be submitted prior to or at the time of the scheduled hearing to be considered for compensation.

☐ Medical and/or dental expenses ☐ Mental health treatment ☐ Funeral/burial

☐ Home or vehicle modifications ☐ Property loss ☐ Income loss *(if you missed work because of the crime)*

Section 4: Incident Information

A corroborating statement and recommendation from the appropriate state or local public safety or law enforcement agency is necessary for determining eligibility.

Law Enforcement or Public Safety Agency Name: _____

Date Incident Occurred: _____ Incident Report Number: _____

Location of Incident: _____

Type of Incident: _____

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.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Section 5: Representative Information (A representative is not needed to apply for compensation.)

This section is for authorized representatives only.

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

First Name: _____ Middle Name: _____

Last Name: _____

Organization Name: _____

Telephone: _____ Extension: _____

Email: _____

Mailing Address

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

Address 2 *(Suite #)*: _____

City: _____ State: _____ Zip: _____

For Attorneys Only

☐ I am requesting payment pursuant to Government Code Section 13973(c).

Tax ID: _____ State Bar Number: _____

Signature and Date Required for all Representatives

Representative's Signature: _____ Date: _____

Section 6: 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: _____ Extension: _____

Mailing Address

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

Address 2 *(Suite #)*: _____

City: _____ State: _____ Zip: _____

Name of Insured

First Name: _____ Middle Name: _____

Last Name: _____

Have you filed an insurance claim related to this incident? ☐ No. ☐ Yes.

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

Complete if the incident involves a vehicle.

Auto Insurance Company Name: _____ Policy Number: _____

Telephone: _____ Extension: _____

Mailing Address

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

Address 2 *(Suite #)*: _____

City: _____ State: _____ Zip: _____

Name of Insured

First Name: _____ Middle Name: _____

Last Name: _____

Have you filed an insurance claim related to this incident? ☐ No. ☐ Yes.

Other Insurance

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

☐ Medi-Cal ☐ Medicare

☐ Workers' Comp ☐ Other *(please specify)*: _____

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

Section 7: Employer Information

Please list the Good Samaritan's employer.

Employer's Business Name: _____

Contact Person

First Name: _____ Last Name: _____

Telephone: _____ Extension: _____

Mailing Address

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

Address 2 *(Suite #)*: _____

City: _____ State: _____ Zip: _____

Is or was the Good Samaritan self-employed?

_____ No. _____ Yes.

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

_____ No. _____ Yes.

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

_____ No. _____ Yes.

Section 8: 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?

_____ No. _____ Yes.

Attorney's Name

First Name: _____ Middle Name: _____

Last Name: _____

Telephone: _____ Extension: _____

Mailing Address

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

Address 2 *(Suite #)*: _____

City: _____ State: _____ Zip: _____

Your application for 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 incident-related bills, insurance, or anything relating to the incident. Save original documents for your records.
- Please read the next page carefully, sign and date, and send to the address indicated.
- CalVCB will send you a letter acknowledging that your application has been received.
- A CalVCB representative may contact you for additional information if you were not able to provide it with your application.
- For any questions about Good Samaritan compensation, you can call CalVCB at 1-800-777-9229.

Section 9: Information Release

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

I give permission to any 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, to the California Victim Compensation Board (CalVCB) or its representatives, for the purpose of determining eligibility for CalVCB compensation. 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.

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 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 compensation through the CalVCB Good Samaritan 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 ten (10) years after the date of my signing this form.

Signature: _____ Date: _____

Section 10: My Agreement to the California Victim Compensation Board

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

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 incident 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 incident or if I pursue any action on my own.

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.

Printed Name: _____

Signature: _____ Date: _____

Mail completed application to:

California Victim Compensation Board
P.O. Box 3036, Sacramento, CA 95812-3036

For more information call:

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