STATE OF CALIFORNIA

INCOME/SUPPORT LOSS REQUEST

VCB-31-10029 (Rev. 06/2026)

CalVCB Application Number: _____

This form must be completed for all income or support loss requests and renewals.

Victim's Name (Print): _____ Date of Injury: _____

Dates of Disability Period: From (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____

Treating Medical or Mental Health Provider Name: _____

Treating Medical or Mental Health Provider Address: _____ Phone Number: _____

Employer Name and Work Site: _____ Phone Number: _____

Employer Address: _____

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.

Signature: _____ Date: _____

If you have a job and your disability lasts one year or less, you must apply for State Disability Insurance (SDI) through the Employment Development Department (EDD). If your disability lasts longer than one year, you must apply for Social Security Disability Insurances (SSDI) through the Social Security Administration (SSA). You must give the Board proof that you applied. You must also provide the response showing if your claim was approved or denied, and how much money you will receive.