STATE OF CALIFORNIA

Forced or Involuntary Sterilization Compensation Program Application

VCB–31–10002 (Rev. 12/2021)

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 PO 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 PO 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 PO 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 PO 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: 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
PO 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)