APP USE ONLY

Click or tap

DEPARTMENT OF JUSTICE
APPELLATE ADVOCACY PROGRAM
BENEFIT INFORMATION

Applicant Name (full legal name): ________________________________

Date of Birth: ____________________

Mailing Address: ____

Email: _____________________ Telephone Number: _______________

Is anyone authorized to get information about your claim?

TO BE COMPLETED BY ADVOCATE OR OTHER AGENCY PERSONNEL

☐Check here if you are not working with a District Attorney or DOJ Advocate

OFFENDER'S NAME:_________________ DOB: ___________________

COUNTY OF CONVICTION: _______________ COUNTY CASE NUMBER: ________

- BY SIGNING THIS STATEMENT, I HEREBY CONSENT TO RELEASE RECORDS from medical providers to the Crime Victim Compensation Program for the purpose of billing and/or reimbursement of payments made for counseling services received.
- BY SIGNING THIS STATEMENT, I declare that the information in this application is true and accurate. I, or we, authorize the Crime Victims' Compensation Program of the Department of Justice to verify any information on this application.

☐ CLICK HERE TO ENTER ELECTRONIC SIGNATURE ______________________

Date:______________

PLEASE CHECK ONE OF THE BOXES BELOW

☐ This authorization expires when the post-conviction and/or appeal ends

☐ This authorization expires on _______________