STATE OF CALIFORNIA
Victim Compensation and Government Claims Board (VCGCB)
VCGCB-VOC-6035 (Rev. 05/05)

For staff use only:
Meets Relocation Criteria Yes ☐ No ☐
Initial: _____

Mental Health Provider Relocation Benefit Verification Form

This form is to help mental health providers document a threat to the emotional well-being of a crime victim seeking relocation benefits from the Victim Compensation Program (VCP) pursuant to GC § 13957(a)(8). This form may be used with or without a letter from the mental health provider. If a letter is submitted without this form, it must be on the provider's letterhead and contain the information requested on this form.

Victim Information		
Name:	SSN:	
Address:		
City:	State:	Zip:
Phone:	VCP Claim No. (if known):	

Crime Information	
Crime Date:	Crime Report Number (if known):
Type of Crime:	Law Enforcement Agency Name:

Mental Health Information		
Provider/Organization Name:		License No./Expr. Date:
Treatment Dates:	No. of Sessions:	Is Treatment Ongoing?:

Please explain why relocation is necessary for the victim's emotional well-being and describe the consequences the victim faces if he or she does not relocate:
Will you be providing supportive counseling services or referring the victim to an intern, or a domestic violence or sexual assault program? Please explain:

When Completed by Mental Health Provider	
Mental Health Provider Name:	Phone No.:
Signature:	Date:

If MH Form is <u>not</u> fully completed by MH Provider contact the Provider, complete the missing information in red ink and complete this section	
Mental Health Provider Supplying Information:	Phone No.:
VW Center Advocate or VCP Staff Completing This Form:	Phone No.:
VW Center Name and Code No.:	Date:

Clear Form **Print Form**