STATE OF CALIFORNIA

RELOCATION MENTAL HEALTH VERIFICATION FORM

VCB-30-19230 (Rev. 06/2024)

CalVCB Application No.: _____

Instructions: A statement from the mental health treatment provider is required when a victim of a qualifying crime is requesting relocation benefits from the California Victim Compensation Board (CalVCB) due to crime related emotional trauma. The victim's mental health provider must complete the following information or submit a letter to CalVCB on a prescription pad or letterhead stationery that contains all the information requested in this form including signature and license number. See victims.ca.gov for more details.

Victim Information

Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Crime Information

Crime Date: _____ Type of Crime: _____

Is need to relocate directly related to the qualifying crime? ☐ Yes ☐ No

Did the qualifying crime result in permanent and substantial disability of the victim? ☐ Yes ☐ No

Did victim testify or is victim scheduled to testify as a witness in criminal proceedings related to the qualifying crime and need to relocate is necessary as a result of testifying? ☐ Yes ☐ No

Did the qualifying crime result in substantial impairment of the victim's Activities of Daily Living? ☐ Yes ☐ No

Explain why relocation is necessary for the victim's **emotional well-being**. If the victim's Activities of Daily Living have been substantially impaired, please explain:

Mental Health Provider Information

Mental Health Provider Name: _____ Phone Number: _____

Provider/Organization Address: _____

City: _____ State: _____ Zip: _____

Mental Health Signature: _____ Date: _____

License Number: _____ Expiration Date: _____

***Important Note for Supervised Mental Health Providers!:** Psychology Intern, Psychological Assistant, Associate Social Worker, Sexual Assault Counselor or Certified Child Life Specialist requires a signature from the licensed supervising therapist.*

*Licensed Supervising Therapist Name: _____

*Signature: _____ *Phone Number: _____

*License Number: _____ *Expiration Date: _____

FOR STAFF USE

If form is not fully completed by the treating mental health provider, contact the provider, add the missing information, complete the section below and have the document scanned in.

Mental Health Provider Supplying Information: _____ Phone Number: _____

VW Center Name, Number and Advocate/Staff Completing This Form: _____

Phone Number: _____ Date: _____