



VESC FORM 1004
Application for Filing a Claim for Compensation for
Victims of the 1924 Virginia Eugenical Sterilization Act

Instructions:

1. **Persons eligible to request compensation (“claimant”) must have been:**
 - Sterilized under the 1924 Virginia Eugenical Sterilization Act pursuant to the Code of Virginia Chapter 394 (“Act”)
 - Living as of February 1, 2015; and
 - Sterilized while a patient at Eastern State Hospital, Western State Hospital, Central State Hospital, Southwestern State Hospital, or the Central Virginia Training Center (formerly known as the State Colony for Epileptics and Feeble-Minded) between 1924 and 1981
2. Persons claiming eligibility for compensation who were sterilized under the 1924 Virginia Eugenical Sterilization Act or their lawfully authorized representative must complete this application form and attach the relevant documentation as specified on this form. No application will be processed until the Department determines that it is complete with all documentation.
3. Applications must be notarized.
4. Applications must be mailed individually to the Department through the United States Postal Service. The Department will not accept applications delivered in any other manner and will not accept more than one application in a single mailing.
5. Mail the application form and all supporting documents to:

ATTENTION: Virginia Eugenical Sterilization Act Compensation Program
Virginia Department of Behavioral Health and Developmental Services
P.O. Box 1797
Richmond, Virginia 23218-1797

Section I: Claimant Information (please print)

1. Claimant's Current Name _____
First, Middle, Last
2. Name at Time of Sterilization _____
First, Middle, Last
3. If Claimant's name at time of sterilization was different from current name, attach documentation of name change (e.g., marriage certificate or other documentation).
4. If the Claimant died on or after February 1, 2015, attach a certified copy of a state issued death certificate.
5. Claimants Date of Birth _____/_____/_____
Month Day Year
6. Proof of Identity: **(Check at least one and attach a copy of the document)**
 State issued driver's license
 State issued picture identification card
 United States passport
 Foreign passport with Visa, I-94 or I-94W with picture
 United States military card, active or retired member
7. Current Mailing Address _____

City, State, Zip _____

Phone (____) _____ Email _____

Section II: Documentation of Sterilization Procedure

1. Facility where Claimant was a patient when sterilization was performed **(check one)**
 Eastern State Hospital
 Western State Hospital
 Central State Hospital
 Southwestern Mental Health Institute (Southwestern State Hospital)
 Central Virginia Training Center (State Colony for Epileptics and Feeble-Minded)

2. Date and year of sterilization **(please print)** _____
3. Documentation that the sterilization was performed under the authority of the 1924 Virginia Eugenical Sterilization Act **(check at least one of the following and attach a copy of the documentation)**.
 - ___ Letter notifying a parent, guardian or lawfully authorized representative of the claimant that the sterilization procedure was performed.
 - ___ Progress notes from the claimants hospital record documenting that the sterilization procedure was performed.
 - ___ Case summary from the claimant's hospital record documenting that the sterilization procedure was performed.
 - ___ Physician's order for sterilization from the claimant's hospital record.
 - ___ Operative record of sterilization from the claimant's hospital record.
 - ___ Sterilization record summary from the claimant's hospital record.
 - ___ Nurses notes documenting post-operative care provided to the individual claimant, following the sterilization.
 - ___ Other documents that show proof of sterilization having been performed under the authority of the 1924 Virginia Eugenical Sterilization Act.

Section III: Legally Authorized Representative Information (if applicable)

1. If the person completing the application is doing so on behalf of the Claimant, check one of the following and attach a copy of documentation to prove the legal authority to act on behalf of the Claimant.
 - ___ I am permitted by law or regulation to act on behalf of the Claimant; or
 - ___ I am a personal representative of the estate of the Claimant, as defined in Virginia Code § 64.2-100, of a Claimant who died on or after February 1, 2015.
2. Identifying information of the legally authorized representative of the Claimant **(Print)**

First, Middle, Last Name: _____

Mailing Address _____

City, State, Zip _____

Phone (____) _____ Email _____

Relationship to Claimant _____

Section IV: Certification

I hereby certify the authenticity of the documents referenced in and submitted as evidence for compensation to victims of sterilization. I also hereby acknowledge that I have read the instructions and understand that this application will not be accepted for evaluation or for the award of compensation if it is determined that it has not been prepared in compliance with the instructions.

Signature of Claimant or Claimant's Legally Authorized Representative Date _____

Section V: Acknowledgment of Individual

County/City of _____ Commonwealth Of Virginia.

The foregoing instrument was acknowledged before me this _____ day of _____, 20____,

by _____
Name of person seeking acknowledgement

Notary Public's Signature: _____

Notary's Registration Number: _____

My Commission Expires: _____

Notary Seal