

**VESC FORM 1004 (03/01/17)**  
**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:**
  - Involuntarily 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 Virginia Mental Health Institute, formerly known as Southwestern State Hospital; or the Central Virginia Training Center, formerly known as the State Colony for Epileptics and Feeble-Minded.
2. Individuals 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 considered for compensation or otherwise acted on until the Department determines that it is complete with all documentation.

In regard to Section III, you have two options to satisfy this request:

**A. If someone is signing as the lawfully authorized representative on behalf of the individual,** then as noted on the application, the lawfully authorized representative must complete this application form **and attach the relevant documentation** as specified on the form.

- "Lawfully authorized representative" means (i) a person who is permitted by law or regulation to act on behalf of an individual or (ii) a personal representative of an estate, as defined in § 64.2-100 of the Code of Virginia, of an individual who died on or after February 1, 2015. (12VAC35-240-10)
- **Attach a copy of documentation** to prove the legal authority to act on behalf of the Claimant. (General Power of Attorney, Health Care Power of Attorney, Guardian appointment order)

**OR**

**B.** Fill out the application form and **sign for yourself** and have it notarized (you do not need to resend the other supporting documentation already on file, only a new application form which is enclosed for your convenience). If you are completing the application yourself but would like to authorize the department to discuss your application with another person who is assisting you but who is not the “lawfully authorized representative,” fill out the separate authorization form (attached) to authorize the department to discuss your application with this person. If you are signing the application for yourself, but do not authorize the department to discuss your application with another person, we will only communicate with you.

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: VESC 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 a claimant's current legal name is different from the name at the time of sterilization, attach documentation of name change to prove that he or she is the same individual who is named on the sterilization records. Proof may be a:
  - \_\_\_ Marriage license,
  - \_\_\_ Divorce decree,
  - \_\_\_ Death certificate,
  - \_\_\_ Adoption record,
  - \_\_\_ Court order approving a legal change of name, or
  - \_\_\_ Other legal document indicating an official name change.
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: You must submit a copy of at least one of the following documents. **(Check at least one and attach a copy of each document you check.)**
  - \_\_\_ A state- or United States territory- issued driver's license.
  - \_\_\_ A state government-issued identification card.
  - \_\_\_ A United States passport.
  - \_\_\_ A foreign passport with Visa, I-94 or I-94W.
  - \_\_\_ A United States military card, active or retired member.
  - \_\_\_ A United States military dependent's identification card.
  - \_\_\_ A Native American tribal document, issued by a tribe recognized by the United States federal government.
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 involuntary 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 involuntary sterilization procedure was performed on the claimant.
  - Progress notes from the claimant's hospital record documenting that the involuntary sterilization procedure was performed on the claimant.
  - Case summary from the claimant's hospital record documenting that the involuntary sterilization procedure was performed on the claimant.
  - Physician's order for involuntary sterilization from the claimant's hospital record.
  - Operative record of involuntary sterilization from the claimant's hospital record.
  - Involuntary sterilization record summary from the claimant's hospital record.
  - Nurses' notes documenting post-operative care provided to the individual claimant after involuntary sterilization of the claimant.
  - Other documents that show that the involuntary sterilization was performed on the claimant under the authority of the 1924 Virginia Eugenical Sterilization Act.

**Section III: Lawfully Authorized Representative Information (if applicable)**

1. If the person completing the application is doing so as a lawfully authorized representative 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 (such as, General Power of Attorney, Health Care Power of Attorney, Guardian appointment order); or

\_\_\_ I am a personal representative of the estate, as defined in Virginia Code § 64.2-100, of a Claimant who died on or after February 1, 2015.

2. Identifying information of the lawfully authorized representative of the Claimant **(Print)**

First, Middle, Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Relationship to Claimant \_\_\_\_\_  
(such as General Power of Attorney, Health Care Power of Attorney, Guardian)

**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