RIGHTS IN SYSTEMS ENFORCED

March 23, 2023

California Victim Compensation Board
P.O. Box 3036
Sacramento, CA 95812-3036

Reference: **Application for Crime Victim Compensation**

Dear Sir or Madam:

On behalf of [redacted], I am filing an application for compensation from the California Victim Compensation Board. [redacted] seeks the following victim compensation benefits:

- Income lost as a result of the crime of human trafficking under Government Code sections 13957 and 13957.5;
- Mental Health .

On January 1, 2020, Assembly Bill 629 went into effect amending Government Code sections 13957(a)(3) and 13957.5(a)(5). These amendments enable victims of human trafficking to receive lost income compensation from California Victim Compensation Board. Specifically, they enable the Victim Compensation Board ("Board") to "authorize compensation equal to loss of income or support that a victim incurs as a direct result of the victim's deprivation of liberty during the crime . . . ." Cal. Gov't Code § 13957(a)(3). They also permit the Board to rely on "evidence other than official employment documentation in considering and approving an application [,] . . . including, but not limited to, a statement under penalty of perjury from the applicant, a human trafficking caseworker . . ., a licensed attorney, or a witness to the circumstances of the crime." Cal. Gov't Code § 13957.5(a)(5)(B). This application is timely because it is being made within 7 years of the trafficking crime. Cal. Gov't Code § 13953.

As stated in the attached declaration, Paloma Bustos has found that [redacted] has provided a credible statement that she is a victim of human trafficking. She was trafficked from January 2015 to August 2017 and then again from October 2020 to December 2021, and she lost income as a direct result of the crime. As such, she is eligible to apply for lost income compensation under Government Code section 13957(a)(3). In support of her application, and pursuant to Government Code Section 13957.5(a)(5), the following documents are included with the application:

LIST OF ATTACHMENTS FOR [redacted]

A. Application for Crime Victim Compensation.
B. Human Trafficking Case Worker declaration attesting that the applicant was a victim of human trafficking.
C. Declaration from Applicant demonstrating Income Loss including (1) the dates on which the acts of trafficking commenced and ended, (2) the approximate number of hours per week that a

919 Albany Street, Los Angeles, CA 90015
Phone: (213) 252-7442 Fax:(213) 480-6818
www.lls.edu

Loyola Law School
Loyola Marymount University
Los Angeles

acts of trafficking were performed, and (3) whether reimbursement was or will be received from any other sources.

D. CalVCB Human Trafficking Wage Verification Compensation Form

We respectfully ask for [redacted] request for compensation to be granted. Should you have any questions or concerns, please do not hesitate to contact me. Thank you for your time and cooperation in this matter.

Sincerely,

Stephanie Richard, Esq.
RISE Clinic Director
919 Albany St
Los Angeles, CA 90015
Stephanie.Richard@lls.edu
(213) 736-8148

CC: [redacted]

ATTACHMENT A

CalVCB
CALIFORNIA VICTIM COMPENSATION BOARD

Associated Application ID
(Enter if known)

Application For Crime Victim Compensation

Section 1: Claimant

A separate application must be filed for each person seeking assistance.
Section 1 must be completed for all applications. The claimant is the person who has expenses or is seeking assistance as a result of a crime. If you are filing this application on behalf of someone else, put his/her information in Section 1 and your information in Section 3.

Preferred Spoken Language: ENGLISH

Preferred Written Language: ENGLISH

First Name: [redacted] | Middle Name: | Last Name: [redacted] | Gender: Female

Relationship to Victim: Self (I am the victim) | Social Security Number (SSN): [redacted] | No SSN: ☐ | Date of Birth: [redacted]

Mailing Address

Street Number and Name or PO Box: C/O RISE CLINIC, LOYOLA LAW SCHOOL

From the date of the crime to now, has the **claimant** been in prison, on probation, on parole or post-release community supervision because of a felony? No

Is the **claimant** required to register as a sex offender? No

Address 2 (Apartment or Unit #): 919 ALBANY ST | City: LOS ANGELES | State: CA | Zip: 90015

Best Contact Number: [redacted] | Extension: | E-mail: [redacted] | E-mail Type: Work

☐ **Check this box if you are a parent/guardian applying on behalf of a minor witness to violent crime.** Minor witnesses are eligible for mental health treatment only. Claimant is under age 18, a witness in close proximity to a violent crime, but is neither the crime victim nor related to the victim. Provide available victim, crime or other information in remaining sections.

If you are an adult victim and the expenses are for you, skip to Section 4.

If not, continue to Section 2.

Section 2: Crime Victim

The crime victim is the person who was injured, threatened with injury, or killed due to the crime.

First Name: SAME AS ABOVE | Middle Name: | Last Name: | Gender:

Social Security Number (SSN): | No SSN: ☐ | Date of Birth: | If victim is deceased, date of death:

Mailing Address

Street Number and Name or PO Box:

From the date of the crime to now, has the **victim** been in prison, on probation, on parole or post-release community supervision because of a felony? ☐

Is the **victim** required to register as a sex offender? ☐

Address 2 (Apartment or Unit #): | City: | State: CA | Zip:

Best Contact Number: | Extension: | E-mail: | E-mail Type:

If you are completing this application on behalf of a minor or an incapacitated adult, continue to Section 3.
If not, skip to Section 4.

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Section 3: Parent or Guardian (Applicant)

This section is for parents or guardians of minors or incapacitated adults in Section 1.

Please indicate your relationship to the person listed in Section 1:

Preferred Spoken Language

Preferred Written Language

First Name | Middle Name

Last Name | Date of Birth | Gender | Social Security Number (SSN) | No SSN

Mailing Address

Street Number and Name or PO Box

From the date of the crime to now, have **you** been in prison, on probation, on parole or post-release community supervision because of a felony?

Are **you** required to register as a sex offender?

Address 2 (Apartment or Unit #) | City | State (CA) | Zip

Best Contact Number | Extension | E-mail | E-mail Type

Continue to Section 4.

Section 4: Information About Your Expenses

For the victim of the crime, the following benefits may be available. Please check the crime-related expenses you are requesting. Please attach copies, or a list, of any crime-related bills.

- ☐ Medical and/or dental expenses
- ☑ Mental health treatment
- ☑ Income loss (if you missed work because of the crime)
- ☐ Moving or relocation expenses
- ☐ Home security improvements
- ☐ Home or vehicle modifications (for a victim disabled because of the crime)
- ☐ Job retraining (for a victim disabled because of the crime)
- ☐ Crime scene clean-up
- ☐ Mileage reimbursement or transportation costs

Other crime-related expenses

For someone other than the victim of the crime, the benefits below may be available. Please check the crime-related expenses you are requesting. Please attach copies, or a list, of any crime-related bills.

For minor witnesses to violent crime, only mental health benefits are available. Proceed to Section 5.

- ☐ Mental health treatment
- ☐ Wage loss (up to 30 days if a minor dies or is hospitalized)
- ☐ Loss of support (for dependents of a deceased or disabled victim)
- ☐ Funeral and/or burial expenses
- ☐ Crime scene clean-up
- ☐ Home security improvements
- ☐ Medical expenses for a deceased victim

Emergency Award Request

Emergency awards may be requested in certain situations. An emergency award is intended to pay for crime-related expenses in cases where you will suffer serious financial hardship if crime-related expenses are not immediately paid. Substantial hardship means you would not have any money left for necessities like food or rent after you paid for crime-related bills. Qualifying emergency awards are generally paid within 30 calendar days of receipt of the application.

☐ I am requesting an emergency award.

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Section 5: Crime Information

Law Enforcement Agency Name

If reported to law enforcement, name of the law enforcement agency: SEE CASE WORKER DECLARATION

Dates Crime Occurred

From: | To:

Date Crime was Reported | Crime Report Number | Describe Injuries

Location of Crime (if known)

Address, Intersection, Area, etc. | Address 2 (Ste. #) | City: Los Angeles | State: CA | Zip | County: Los Angeles

Person who committed the crime (suspect), if known ☑ Suspect unknown

First Name | Middle Name | Last Name

Type of Crime: Other

Section 6: Representative Information (A representative is not required to apply for compensation.)

This section is for representatives only. Victim Witness Assistance Center Advocates need only provide phone, name, center #, sign and date. All other representatives, please fill out this section completely.

Please indicate your relationship to the person listed in Section 1: Attorney

If other, please indicate:

First Name: STEPHANIE | Middle Name | Last Name: RICHARD | Telephone: 213-736-8148 | Extension

Organization Name: RISE CLINIC, LOYOLA LAW SCHOOL

Mailing Address

Street Number and Name or PO Box: 919 ALBANY ST | Address 2 (Suite #)

For Victim Assistance Center Staff Only

JP/VWC Number | City: LOS ANGELES | State: CA | Zip: 90015

For Attorneys Only

☐ I am requesting payment pursuant to Government Code Section 13957.7(g).

Tax ID | State Bar Number: 263790

Telephone | E-mail: STEPHANIE.RICHARD@LLS.EDU

Signature and Date Required for all Representatives

Representative's Signature | Date: 3.2.3.2023

Section 7: How Did You Find Out About the Board?

☐ Law Enforcement ☐ District Attorney ☐ Medical Provider ☐ Children's Protective Services

☐ Adult Protective Services ☐ Mental Health Provider ☐ Victim Witness Assistance Center ☐ Media (TV, Radio, Newspaper, etc.)

☐ Billboard or Poster ☐ Card or Booklet ☑ Other: RISE CLINIC, LOYOLA LAW SCHOOL

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Section 8: Federal Reporting Information

The following **voluntary** information is for the person receiving compensation and is used for statistical purposes only to comply with federal regulations.

Ethnicity

- [ ] American Indian/ Alaska Native
- [ ] Asian
- [x] Black/African American
- [ ] Hispanic or Latino
- [ ] Native Hawaiian and Other Pacific Islander
- [ ] White Non-Latino/ Caucasian
- [ ] Other Race
- [ ] Multiple Races
- [ ] Decline to State
- [ ] Other

Is the victim disabled? [ ]

Was the victim disabled prior to the crime? [ ]

Section 9: Insurance Information

Please list your insurance information below. The California Victim Compensation Board (CalVCB) is the payer of last resort. We may contact your insurance company as a potential reimbursement source.

- [ ] I have no insurance of any kind.

Health Insurance

Medi-Cal Benefits Identification Card Number

Issue Date

Health Insurance Company Name

Policy Number

Group Number

Telephone

Ext.

Mailing Address

Street Number and Name or PO Box

Address 2 (Suite #)

City

State: CA

Zip

Name of Insured

First Name

Middle Name

Last Name

Have you filed an insurance claim related to this crime?

Auto/Vehicle Insurance (Includes car, truck, motorcycle, motorhome, boat, jet ski, airplane, etc.)

Complete if the crime involves a vehicle, including pedestrians hit by a vehicle.

Auto Insurance Company Name

Policy Number

Telephone

Ext.

Mailing Address

Street Number and Name or PO Box

Address 2 (Suite #)

City

State: CA

Zip

Name of Insured

First Name

Middle Name

Last Name

Have you filed an insurance claim related to this crime?

Other Insurance

Please check any additional insurance sources that could be applied to your application.

- [x] Medi-Cal
- [ ] Medicare
- [ ] Workers' Comp
- [ ] Other

If you have more than one insurance provider, please list on a separate piece of paper and mail with your application.

CALIFORNIA CalVCB VICTIM COMPENSATION BOARD

Section 10: Employer Information

Please list the victim's employer. If you are a parent/guardian seeking wage loss benefits because a minor victim was hospitalized or is deceased, list your employer.

Contact Person

Employer's Business Name	First Name	Last Name	Telephone	Ext.	OK to contact employer?
EMPLOYER WAS TRAFFICKER					

Mailing Address

Street Number and Name or PO Box	Address 2 (Suite #)	City	State	Zip
			CA	

Is or was the victim self-employed? ☐

Did the victim miss work as a result of crime-related injuries? ☐

Did the crime occur while the victim was on the job or at the workplace? ☐

If you have more than one employer, please list on a separate piece of paper and mail with your application.

Section 11: Civil Suit Information

If you decide to file a civil suit, by law, you are required to notify CalVCB within 30 days of filing the action.

Have you filed, or do you plan to file, a civil suit related to this crime? No

Attorney's Name

First Name	Middle Name	Last Name	Telephone	Extension

Mailing Address

Street Number and Name or PO Box	Address 2 (Suite #)	City	State	Zip
			CA	

Your application for crime victim compensation is almost complete.

- After entering all available information, print the application.
- Attach copies of any documentation that supports your application for crime victim compensation, including copies of crime-related bills, insurance, or anything relating to the crime. Save original documents for your records.
- Please read the next page carefully, sign and date, and send to the address indicated or deliver to your local Victim Witness Assistance Center.
- CalVCB will send you a letter acknowledging that your application has been received. The acknowledgment letter will include additional information about the benefits requested on your application.
- A CalVCB representative may contact you for additional information if you were not able to provide it with your application.
- For any questions about victim compensation, you can contact your local Victim Witness Assistance Center or call CalVCB at 1-800-777-9229.

CalVCB

Print | Save | Clear

This page **must** be signed and dated.

Section 12: Information Release

I give permission to any healthcare provider; any medical biller, any funeral director or similar persons, any employer, any police or other government agency, including the Department of Justice, the Social Security Administration, the State Franchise Tax Board, and the Federal Internal Revenue Service; any insurance company; or any other person or agency, to provide information relating to this application, including medical (including, but not limited to history or physical records, consultation reports, pathology reports, discharge summaries, operative reports, X ray and other radiology reports, laboratory reports, chart notes, narrative reports, and billing records), mental health, and felony conviction records, to the California Victim Compensation Board (CalVCB) or its representatives, for the purpose of determining eligibility for CalVCB benefits. This permission also applies to all sources of recovery for the claimed losses, including but not limited to, health or medical benefits, unemployment or disability benefits, Social Security benefits (Social Security disability, Supplemental Security income, and/or retirement, including the supporting medical and/or mental health records), and Veteran benefits. I also give permission for the release of federal and state tax information, including tax returns, for the purpose of verifying income. I hereby waive all legal privileges to any of this information required by CalVCB regarding my claim.

I agree that a photocopy or fax of this signed form is as valid as the original, and my signature gives permission for the release of all specified information.

I agree that CalVCB or its representatives may pursue restitution from the convicted offender in this matter to recover monies paid to me by CalVCB and that by filing this application I have authorized use of information in this application and subsequent claim files to pursue restitution from the convicted offender.

In order to verify or process this application, I agree that CalVCB or its representatives may provide information about this application, and the information contained in this application, to any representative named on this application, government agency, or health care provider or other provider of services, and may pay the provider directly if payment of these services is approved.

I agree that I may revoke this authorization at any time. The revocation must be in writing. The revocation will take effect when CalVCB receives it, but I may be deemed ineligible for CalVCB benefits once the revocation is received by CalVCB. However, no healthcare provider may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I am entitled to a copy of this authorization except in limited circumstances. I agree that information disclosed under this authorization may be redisclosed by the recipient as required by law and this redisclosure may no longer be protected by federal or state law.

I agree that the authorizations and agreements herein will expire ten (10) years after the date of my signing this form.

Signed [redacted]	Date 03/23/2023

(Parent or guardian must sign if victim is a minor or incapacitated.)

Section 13: My Agreement to the California Victim Compensation Board

As required by California law, I will contact and repay the California Victim Compensation Board (CalVCB) if I, or anyone on my behalf, receives any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private entity, for losses suffered as a direct result of the crime that was the basis for receipt of benefits from CalVCB, in the amount of the total benefits granted by CalVCB. I understand I may be responsible for repaying CalVCB any amount for which it is later determined that I was not eligible. I will notify CalVCB if I hire an attorney to represent me in any action related to this crime or if I pursue any action on my own.

Any monies I receive from CalVCB for moving/relocation expenses, improving home security, or for modifying a home or vehicle for a disabled victim will be used only for those purposes. If I am a victim of domestic violence receiving moving/relocation expenses, I will not tell the offender my home address nor allow the offender on the premises at any time, or I will seek a restraining order against the offender.

In the event that I am compensated for any pecuniary loss by CalVCB and the State of California subsequently receives compensation for the same loss on my behalf from the perpetrator (including any monies received through a restitution order) or from any other source, I hereby assign to the Victim Compensation Board any and all rights to such duplicate compensation.

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct and completed to the best of my knowledge and belief. I understand that I may be found to be ineligible for benefits, and that action may be taken to recover benefits I receive if I provide information that is false, intentionally incomplete, or misleading.

Signed [redacted]	Date 03/23/2023

(Parent or guardian must sign if victim is a minor or incapacitated. County social workers, see section 13a.)

Printed Name [redacted]

Section 13a: For County Social Workers Only

As required by California law, I will contact and inform the California Victim Compensation Board (CalVCB) if I learn the claimant receives any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private entity, for losses suffered as a direct result of the crime that was the basis for receipt of benefits from CalVCB.

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct and completed to the best of my knowledge and belief. I understand that the claimant may be found to be ineligible for benefits, and that action may be taken to recover benefits the claimant receives if the claimant provides information that is false, intentionally incomplete, or misleading.

Signed	Date
Printed Name	

Mail completed application to:

California Victim Compensation Board
PO Box 3036, Sacramento, CA 95812-3036

or

deliver to your local Victim Witness Assistance Center

For more information call:

1-800-777-9229

Hearing impaired, please call the California Relay Service (711)

victims.ca.gov *Helping California Crime Victims Since 1965*

ATTACHMENT B

RIGHTS IN SYSTEMS ENFORCED

Case Worker Declaration

I, Paloma Bustos, hereby declare under penalty of perjury, that I am a Case Worker for victims of human trafficking and I am employed for a human trafficking victim's services organization as defined by California Evidence Code § 1038.2(c) & (d).

I have been a Case Worker for victims of human trafficking and domestic violence for over 5 years. I hold a master's degree in Social Work from San Jose State University.

I am currently employed with the Rights in System Enforcement (RISE) Clinic at Loyola Law School. The RISE Clinic:

(1) Employs staff that meet the requirements of a human trafficking case worker as set forth in this section.
(2) Operates a telephone hotline, advertised to the public, for survivor crisis calls.
(3) Offers psychological support and peer counseling provided in accordance with thissection.
(4) Makes staff available during normal business hours to assist victims of human trafficking who need shelter, programs, or other support services.

I declare that [redacted] was subjected to the following:

1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion or in which the person induced to perform such an act is under 18; and
2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor services, through the use of force, fraud, or coercion, for the purpose of subjecting that person to involuntary servitude, peonage, debt bondage, or slavery.

I declare under penalty of perjury that the foregoing statement is true and correct, and I am aware that if I present any material matter as true which I know to be false, I may be subjected to penalties prescribed for perjury under the Penal Code of the State of California in accordance with Section 11054 of the Welfare and Institutions Code.

Executed in Los Angeles, California, this 23 day of March, 2023.

Declarant's Signature Paloma Bustos

919 Albany Street, Los Angeles, CA 90015
Phone: (213) 252-7442 Fax:(213) 480-6818
www.lls.edu

Loyola Law School
Loyola Marymount University
Los Angeles

ATTACHMENT C

Declaration Under Penalty of Perjury

I [redacted]

Hereby declare that I was a victim of human trafficking, where I was subjected to the following:

1. The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion, for the purpose of subjecting that person to involuntary servitude, peonage, debt bondage, or slavery.

2. My trafficking began in *January 2015* and ended in *August 2017*. I was trafficked again from *October 2020* to *December 2021*.

3. I was forced to perform commercial sex and labor services for my trafficker for approximately 40 hours or more a week during my trafficking and did not receive any payment.

4. I have not received compensation for lost income or services from any other source.

I declare under penalty of perjury that the foregoing statement is true and correct, and I am aware that if I present any material matter as true which I know to be false, I may be subjected to penalties prescribed for perjury under the Penal Code of the State of California in accordance with Section 11054 of the Welfare and Institutions Code.

Executed at [Los Angeles], California, this 03/23/2023.

Signature [redacted]

ATTACHMENT D

CALIFORNIA CalVCB VICTIM COMPENSATION BOARD

Human Trafficking Wage Compensation Verification Form

CalVCB Application ID:

Victim's Name: [redacted] **Victim's Date of Birth:** [redacted]

Applicant's Name: (if victim is a minor) SELF **Relationship to Victim:** SELF

Email Address: [redacted] **Phone Number:** [redacted]

Type of Crime: ☑ Sex Trafficking ☑ Labor Trafficking

Date(s) Crime Occurred: From (mm/dd/yyyy): To (mm/dd/yyyy):

Were the acts of trafficking performed 40 or more hours per week? ☑ Yes ☐ No

If answered "No" to previous question, how many hours per week?

Has the victim received or will the victim receive wage compensation by any other source as a result of the human trafficking crime? ☐ Yes ☑ No

If answered "Yes", list ALL sources:

Amount: $

DISCLAIMER:

CalVCB is the payor of last resort. Compensation for loss of income for crimes of Human Trafficking shall not exceed ten thousand dollars ($10,000) per year that the services were performed, for a maximum of two years and if the victim is a minor at the time of application, the board shall distribute payment when the minor reaches 18 years of age. (California Government Code Section 13957.5(a)(5)(C) & (D))

DECLARATION:

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: I have read all of the questions contained on this verification form, and to the best of my information and belief, all my answers are true, correct, and complete. I further understand that if I have knowingly provided any information that is false, intentionally incomplete, or misleading, I may be found liable for filing a false claim with the State of California, and may be liable for up to three times the amount of damages the State of California sustains, in addition to the costs of a civil action brought to recover any of those penalties or damages; or for a civil penalty of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000) for each false claim. (California Government Code, sections 12650-12656) Finally, I understand that if I have intentionally provided any information that is false, incomplete, or misleading, I may be guilty of a misdemeanor punishable by up to one year in the county jail and/or a fine of up to one thousand dollars ($1,000), or a felony punishable by up to three years in state prison and/or a fine of up to ten thousand dollars, ($10,000). (California Penal Code, sections 17, 18, and 72)

Check the box that corresponds with the person who is completing and signing this form.

☑ Victim ☐ Applicant ☐ Witness to the Crime ☐ Human Trafficking Caseworker

☐ Law Enforcement Agency ☐ Licensed Attorney Lic.# ☐

☐ Other ☐

Printed Name: [redacted] **Signature:** [redacted] **Date:** 03/23/2023

Title: **Agency (if applicable):**

If you have any questions, please call our Customer Service Unit toll-free at 1-800-777-9229.