CLARK COUNTY
OFFICE OF THE DISTRICT ATTORNEY
Criminal Division

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VACANT *Director D.A. Family Support*
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Clark County Sexual Assault/Abuse Compensation Application

I, declare under penalty of perjury under the law of the State of Nevada that the foregoing is true and correct:

1. That I am the victim of sexual assault or the spouse of such victim or the parent or legal guardian of such victim;
2. That the sexual assault/abuse occurred in Clark County on the _____ (date);
3. That medical treatment is required for the physical injuries resulting from the sexual assault/abuse and/or that counseling is required for the emotional trauma resulting from the sexual assault/abuse;
4. That I hereby request monetary assistance from Clark County to pay for such treatment or counseling;
5. That a written report concerning the sexual assault/abuse was filed with the _____ (name of law enforcement agency) on _____ (date), ,DR/EVENT #_____;
6. I agree to reimburse Clark County for the assistance provided pursuant to this application to the extent of any recovery of damages against the offenders or other responsible person paid to me as a result of the above-referenced sexual assault/abuse; and, I hereby assign to the Clark County Sexual Assault and Abuse Victim program any rights to recover from such persons or entities to the extent of payments made on my behalf and I agree to cooperate in the collection of such payments;
7. **AUTHORIZATION:**
   I hereby authorize all doctors, dentists, psychologists, pharmacists, hospitals, marriage and family therapists, clinical social workers, labs, or others providing care, treatment consultation, drugs or supplies to furnish the Clark County Sexual Assault/Abuse Claim Compensation with full information and copies of records regarding history, physical, or mental conditions, consultations, treatment or psychotherapy rendered to me. I understand that this information may be disclosed to other law enforcement agencies and be discovered in legal proceedings.

   I also authorize Clark County Sexual Assault/Abuse Claim Compensation to release any information relevant to payment and processing of claims, coordinating of benefits provision to any insurance carrier, service plan, union, trust fund or the State of Nevada Victims of Violent Crime Program, should they request such information.

   This authorization for information and copies of records expires five (5) years from the date of this application and may be revoked at any time prior to receiving benefits from this Program. A photocopy of this authorization shall be considered as effective and valid as the original.

MANDATORY: VICTIM'S DATE OF BIRTH AND POLICE REPORT/EVENT NUMBER ARE REQUIRED, OTHERWISE THIS APPLICATION WILL NOT BE PROCESSED. PRINTED NAME OF PARENT/GUARDIAN REQUIRED.

_____
Signature of Applicant/Parent or Guardian

_____
Printed Name of Applicant/Parent or Guardian

_____
Address

_____
City/State/Zip

_____
Area Code and Phone Number

_____
Victim's Name

_____
Address

_____
City/State/Zip

_____
Victims Date of Birth & Victim's Social Security Number