



**U.S. Department of Justice**  
**September 11<sup>th</sup> Victim Compensation Fund**

OMB NO.: 1105-0079  
 EXPIRATION DATE: 6/30/2004

P.O. Box 18698  
 Washington, DC 20036-8698

**Application For Representative Payee**

1. Your Name: \_\_\_\_\_
2. Victim Name: \_\_\_\_\_
3. Claim Number: \_\_\_\_\_
4. Date of Birth: \_\_\_\_\_
5. Social Security Number: \_\_\_\_\_
6. Any Other Name You Have Used: \_\_\_\_\_
7. Name of Minor(s) for Whom You Are Filing As Representative Payee:

Name	Date of Birth	Social Security Number	Amount

8. Are you the natural or adoptive parent of the minor(s)? Yes  No
  
9. Do you live with and/or have custody of the minor(s)? Yes  No   
 If no, please explain (If you need more space, attach a separate sheet):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
10. Does a parent outside the household share custody of the minor(s)? Yes  No
  
11. Have you ever been convicted of a felony? Yes  No   
 If yes, please explain (If you need more space attach a separate sheet):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
12. I request that the award(s) to the minor(s) listed above be paid to me as representative payee .



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**Please Read The Following Carefully Before Signing This Form**

**I Acknowledge** that I must use the award(s) paid to me as representative payee for the minor(s) current needs or, if not currently needed, to save them for his or her future needs. I acknowledge that I may be held liable if I do not prudently invest funds, maintain separate accounts, maintain records or if I misuse or misappropriate the award paid to me as representative payee. I acknowledge that, upon reaching 18 years of age (or age of majority in applicable state), the minor(s) is/are entitled to receive the award paid to me as representative payee and that, at such time, I must distribute the award to the minor(s) unless the minor(s) otherwise consent(s). The United States government and agents thereof are fully discharged of responsibility upon receipt of this award. I agree to defend, indemnify, and hold harmless, at my own expense, the United States of America, and all of its present and former agents, employees and agencies, from any and all claims arising from or in any way relating to any actions I may take, or any omissions I may make, in my role as representative payee.

**I Further Acknowledge** that anyone who makes or causes to be made a false statement or representation of material fact relating to a payment from the September 11<sup>th</sup> Victim Compensation Fund, or agents thereof, commits a crime punishable under federal law. I affirm that all the information I have given in this document is correct.

\_\_\_\_\_  
Name (please print first, middle and last)

\_\_\_\_\_  
Signature  
(Sign in the presence of Notary Public)

\_\_\_\_\_  
Date

**Official Notarization:** Please have this page certified by a Notary Public (or equivalent for non-U.S. applicants). The Notary Public should apply seal to this page.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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### **Privacy Act Notice**

The Department of Justice is authorized to collect this information by the September 11<sup>th</sup> Victim Compensation Fund of 2001, Title IV of Public Law 107-42, Stat.230 (“Air Transportation Safety and System Stabilization Act.”). The information you submit is for official use by the U.S. Department of Justice for the purposes of determining your eligibility as a Representative Payee. Provision of this information is voluntary; however, failure to provide complete information may result in a denial of your application for representative payee. Information you submit regarding your application for representative payee may be disclosed by the Government only in accordance with the provisions of the Privacy Act.

### **Paperwork Reduction Act Notice**

Under the Paperwork Reduction Act, a person is not required to respond to a collection of information unless it displays a valid OMB control number. We try to create forms and instructions that are accurate, can be easily understood, and which impose the least possible burden on you to provide us with information. The estimated average time to complete the form is 30 minutes. A survey contact person will call each agency to answer questions and to facilitate getting the information in an effort to make the response reasonable, easier to complete, and less time-consuming. If you have comments regarding the accuracy of this estimate, or suggestions for making this form simpler, you can write to the Victim Compensation Fund, P.O. Box 18698, Washington, D.C. 20036-8698.