Diocese of Scranton
Independent Survivor Compensation Program ("ISCP")
CLAIM FORM

Please read the following before completing the Claim Form.

General instructions for completing your Claim Form:

- Please type or print clearly.
- Provide accurate contact information where you can be reached and update the Program if that information changes.
- Provide as much corroborating documentation for your claim as you can. On the last page of the Claim Form, check the box for or describe the documentation you are providing.
- You do not need to submit documents you or your medical providers previously provided to the Diocese.
- If a Legal Representative is completing the Claim Form on behalf of the claimant, be sure to include proof of legal representation.
- Be sure to sign the last page of the Claim Form before a notary, and have the notary sign and stamp the Claim Form.
- If you would like assistance in completing your claim form please contact the Administrators at 833-328-3389.
- Please see the enclosed list of Frequently Asked Questions, which provides answers to common questions about the Claim Form and types of documents you may wish to include.

To submit your claim:

- Mail the completed Claim Form via overnight courier (using the pre-paid courier voucher included in this packet) to the Independent Claims Administrator at the following address:

  The Independent Survivor Compensation Program
  for the Diocese of Scranton
  c/o Law Offices of Kenneth R. Feinberg PC
  1455 Pennsylvania Avenue, NW – Suite 390
  Washington, DC 20004

- All Claim Forms should be postmarked or submitted by **SEPTEMBER 30, 2019**.

QUESTIONS?

If you have questions about the Program, the claims administration process, or the status of your claim, please contact the Independent Claims Administrators via email at ClaimantServices@ScrantonDioceseISCP.com or telephone at 833-328-3389.

PLEASE ANSWER ALL QUESTIONS, ATTACHING ADDITIONAL PAGES AS NECESSARY

Claimant Name and Contact Information:

First Name: _____ Middle Name: _____

Last Name: _____

Other Names Used: _____

Date of Birth (mm/dd/yyyy): ____/____/____ SSN: _____-_____-_____

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____

Best phone number to reach you: ☐ Home ☐ Mobile ☐ Work _____

Email: _____

How would you prefer we communicate with you? (Check all that apply) ☐ Mail ☐ E-mail ☐ Phone

NOTE: It is important that you inform the Program if you change your address, e-mail address, or phone number. To process your claim, we must be able to contact you.

Attorney or Other Representation: *(if applicable)*

Name: _____ Firm: _____

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

I. ELIGIBILITY

1. Name of Abuser: _____

2. Name of Church/Parish: _____

   Address of Church/Parish: _____

   _____

3. Where did the abuse occur?

   _____

   _____

   _____

   _____

   _____

4. Approximately how old were you when you were first sexually abused? _____

5. When did the abuse occur? (Please list the approximate date(s) abuse happened to the best of your knowledge):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

6. On approximately how many separate occasions were you sexually abused? _____

7. To the best of your ability, describe the nature of the sexual abuse (to complete Section 7 you may attach additional pages as necessary):

   _____

   _____

   _____

   _____

8. Was the abuse reported to:

Parents, Family Members, Friend, other: ☐ Yes ☐ No

If Yes, please provide name and date:

District Attorney's Office: ☐ Yes ☐ No

If Yes, please provide name and date: _____

Police Department or Other law enforcement official: ☐ Yes ☐ No

If Yes, please provide name and date: _____

The Church/Parish: ☐ Yes ☐ No

If Yes, please provide name and date: _____

9. Did you receive a prior financial settlement from the Diocese? ☐ Yes ☐ No

If yes, please provide the approximate date and amount of the settlement and attach a copy of the settlement agreement.

10. Do you currently have a civil lawsuit against the Diocese? ☐ Yes ☐ No

If yes, you must dismiss the lawsuit prior to accepting the compensation offered by the IRCP and provide confirmation of the dismissal to the Administrators.

II. ADDITIONAL INFORMATION IN SUPPORT OF CLAIM

11. Did anyone witness the abuse or circumstances surrounding the abuse? ☐ Yes ☐ No

If yes, please provide the name(s) of the witnesses & dates of the incidents the person witnessed.

12. To the best of your ability, please describe the impact (emotional, spiritual, financial, etc.) you believe the abuse had on you (to complete Section 11 you may attach additional pages as necessary):

13. Treatment and Services:

Have you received any treatment or services (medical, counseling, addiction, spiritual or religious) related to the abuse provided by the Diocese? ☐ Yes ☐ No

Have you received any treatment or services (medical, counseling, addiction, spiritual or religious) related to the abuse from a source other than the Diocese? ☐ Yes ☐ No

If yes, please describe and provide the name of the service provider and a description of the services:

Are you currently receiving such services? ☐ Yes ☐ No

If yes, please specify the services currently being received:

Are there other services you believe would assist you? ☐ Yes ☐ No

If yes, please specify:

III. SUPPORTING DOCUMENTATION

Please complete this section for the documentation you are providing in support of your claim.

Supporting Documentation: *(please check):*

I have attached the following required documentation:

☐ Proof of Legal Representation (if applicable) *(Retention Agreement signed by both the attorney and the claimant.)*

☐ Proof of Relationship to Victim if filing on Victim's behalf

☐ Marriage License ☐ Other:_____

☐ Medical/Counseling Records

☐ Proof of Dismissal of lawsuit against the Diocese

☐ Other: _____

IV. VERIFICATION

This portion of the Claim Form must be signed and notarized to be eligible for consideration.

I hereby certify that the information provided in this Claim Form is true and accurate to the best of my knowledge. I understand that false statements or claims made in connection with this claim may result in fines, imprisonment and/or any other remedy available by law.

Claimant Signature: _____

Printed Name:

First:_____Middle:_____Last: _____

Date: _____

Notary Signature:

State/Commonwealth of:_____ County of: _____

The foregoing instrument was subscribed and sworn before me this____day of_____, 20____ by_____.

My Commission expires:_____ Affix Seal Here:

Signature of Notary: _____

Date: _____