OFFICE OF THE ATTORNEY GENERAL
VICTIM COMPENSATION DIVISION

P.O. Box 220
Jackson, MS 39205-0220
Phone: 1-800-829-6766 or 601-359-6766
Fax: 601-576-4445

AUTHORIZED CONTACT - REQUEST FORM - (Optional)

This form may only be completed by the victim

If you would like for someone, in addition to yourself, to have permission to speak with this Division about your Victim Compensation Claim, you must complete this form and return it to this office. NOTE: A provider may not be an authorized contact.

INSTRUCTIONS: To add an Authorized Contact, please complete **all** sections of this form, sign and return the completed form to the Victim Compensation Division at the address or fax number above. NOTE: A witness signature is also required. The witness cannot be the "authorized contact."

Victim Compensation Claim Number: _____

Your Information (Please Print):

Victim's Name: _____

Social Security Number: _____ Date of Birth: ____ / ____ / ____

Authorized Contact Information (Print the name and contact information of the person who may speak with the Victim Compensation Division about your victim compensation claim.):

Name: _____

Relationship to You: _____

Mailing Address: _____

City: _____, State: _____, Zip Code: _____

Phone number(s): _____ (home or cell), _____ (work)

I authorize the Victim Compensation Division to speak with the above named person on my behalf regarding my Victim Compensation Claim, within the limits allowed by law and administrative rule.

I understand that authorizing the above named person to speak with the Division about my claim is voluntary.

I will contact the Division if the authorized contact's contact information changes or if I choose to withdraw this authorization.

*Victim's Signature _____ Date _____

*Signature of Witness _____ Date _____
*Both signatures are required. (The witness signature is of someone who is present and actually watches the victim sign this document, but cannot be the "Authorized Contact" named in the box above.)

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AUTHORIZED CONTACT - REQUEST FORM (Optional)

This form may only be completed by the claimant

If you would like for someone, in addition to yourself, to have permission to speak with this Division about your Victim Compensation Claim, you must complete this form and return it to this office. NOTE: A provider may not be an authorized contact.

INSTRUCTIONS: To add an Authorized Contact, please complete **all** sections of this form, sign and return the completed form to the Victim Compensation Division at the address or fax number above. Note: A witness must also sign this document. The witness cannot be the "authorized contact."

Victim Compensation Claim Number: _____

Victim Information (Please Print):

Victim's Name: _____

Victim's Social Security Number: _____, Victim's Date of Birth: ___ / ___ / ___

Your Information (Please Print):

Claimant's (Your) Name: _____

Social Security Number: _____ Date of Birth: ____ / ____ / ____

Authorized Contact Information (Print the name and contact information of the person who may speak with the Victim Compensation Division about your victim compensation claim.):

Name: _____

Relationship to Victim: _____

Mailing Address: _____

City: _____, State: _____, Zip Code: _____

Phone number(s): _____ (home or cell), _____ (work)

I authorize the Victim Compensation Division to speak with the above named person on my behalf regarding my Victim Compensation Claim, within the limits allowed by law and administrative rule.

I understand that authorizing the above named person to speak with the Division about my claim is voluntary.

I will contact the Division if the authorized contact's contact information changes or if I choose to withdraw this authorization.

*Claimant's Signature _____ Date _____

*Signature of Witness _____ Date _____

*Both signatures are required. (The witness signature is of someone who is present and actually watches the claimant sign this document, but cannot be the "Authorized Contact" named in the box above.)