IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA
Manuel de Jesus Ortega Melendres, et al. v. Paul Penzone, et al.
CV-07-2513-PHX-GMS

MEL0001

CLAIM FORM

INSTRUCTIONS

Benefits under this program (the "Compensation Fund") will be available to individuals, regardless of immigration status, stopped and held by Maricopa County Sheriff's Office (MCSO) between December 23, 2011, and May 24, 2013 in violation of a Preliminary Injunction issued by a federal court in the *Ortega Melendres v. Penzone (previously Arpaio)* litigation. The Preliminary Injunction prohibited MCSO deputies from detaining a person solely on the basis that MCSO personnel believed the person was in the U.S. without authorization. A detention occurs whenever an individual is not free to leave law enforcement custody. Detention for the purposes of the Compensation Fund may include being transported in a motor vehicle by an MCSO deputy or other law enforcement officer, held at the side of the road by an MCSO deputy, or placed in a cell.

You must submit a signed copy of this Claim Form no later than December 3, 2018 the deadline for all claimants in the Compensation Fund outlined in the Court's Order Re Victim Compensation. Reliable proof of identity must accompany the Claim Form (this may include, but is not limited to a driver's license, resident alien number, birth certificate, passport, or other proof of identity). **All claimants must complete Section I and sign Section VII.** If you did not receive a letter directly from the Claims Administrator saying you are eligible for a payment, you must also complete Section II. If you would like to apply for additional payment for damages other than detention by MCSO, such as subsequent detention by federal authorities or for injuries like physical harm, severe emotional distress, or loss of wages or property, you must complete Section III. Note: applying for additional benefits may result in a longer processing time. If you are seeking compensation in this program for medical expenses, you must provide your Social Security Number, if you have one. You will not automatically be excluded from compensation for medical expenses if you do not have a Social Security Number.

If you are not sure whether you are eligible to participate in the Compensation Fund, you may call 1-844-500-6327 with questions or visit www.maricopasheriffcompensationfund.org.You may also contact an attorney or call 602-773-6022 to ask about attorneys who may be able to help you for free. If you have an attorney, he or she may complete this Claim Form for you, but you must personally sign Section VII.

I. INFORMATION REQUIRED FROM ALL CLAIMANTS

A. CLAIMANT INFORMATION

If you are filing this claim on behalf of yourself complete this section. If you are an authorized representative, please enter the detainee's information.

Name	Last		First	MI
Address	Street/P.O. Box			
	City	State	Zip	Country
Daytime Telephone Number	(_____) _____-_____		**Evening Telephone Number**	(_____) _____-_____

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Email Address			
Date of Birth	--_____/--____/---____ (month) (day) (year)	**Social Security Number if applicable (see instructions above)**	_____ - _____ - _____
Other Proof of Identity This could be a Driver's License, Resident Alien Number, Birth Certificate, or Passport or anything else that shows who you are. You need this only if you did not provide a Social Security Number above. Be sure to attach a copy of your proof when you submit this form.			

B. LAWYER INFORMATION (if represented by a lawyer)

Lawyer Name	Last	First		MI
Law Firm Name				
Address	Street/P.O. Box			
	City	State	Zip	Country
Telephone Number	(_____) _____-_____	**Fax Number**	(_____) _____-_____	
Email Address				

C. PERSONAL REPRESENTATIVE INFORMATION FOR DECEASED, MINOR, OR INCAPACITATED CLAIMANTS

If you are a Representative Claimant, complete this section. If you are NOT a Representative Claimant, skip this section and go to Section D. A Representative Claimant is an authorized representative, ordered by a court, administrative official, or otherwise authorized under applicable state law, or law of applicable country, of a deceased, minor or legally incapacitated or incompetent individual.

Is the individual for whom you are acting Deceased, minor or legally incapacitated or incompetent?	☐ Deceased ☐ Minor ☐ Legally Incapacitated or Incompetent

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Relationship to Claimant (check all that apply)	☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Administrator ☐ Executor ☐ (specify)			
Name	Last	First	MI	
Address	Street/P.O. Box			
	City	State	Zip	Country
Daytime Telephone Number	(_____) _____-_____	**Evening Telephone Number**	(_____) _____-_____	
Email Address				

☐ I certify I have legal authority to file this claim on behalf of the individual identified in Section A.

D. DETENTION BY MCSO

1.	**Check here to confirm you were stopped by MCSO between December 23, 2011 and May 24, 2013.** ☐ YES, I believe I was stopped by MCSO between December 23, 2011 and May 24, 2013.			
2.	**How long did MCSO stop and hold you for? Please check the appropriate box. If you do not know the exact length of time, please estimate the length. If you were stopped and held by MCSO for over one hour, please list the approximate amount of time in the space provided.** ☐ 0-20 Minutes ☐ 21-60 Minutes ☐ Over 60 Minutes: _____			
3.	**When did the stop by MCSO occur? Provide a 30-day date range if precise date is unknown.** --_____/_--____/----____ (month) (day) (year)			
4.	**What was the type of encounter (traffic stop, other)?**			
5.	**Name Provided to MCSO (if different than name listed above)**	**Last**	**First**	**MI**

II. MCSO DETENTION DETAILS

If you received a notice letter directly from the Claims Administrator and are not seeking additional compensation for other injuries beyond just your detention by MCSO, you may skip this Section. All other claimants must complete this Section.

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1.	**How do you know you were stopped by MCSO, as opposed to another law enforcement agency (uniform, patrol car, etc.)?**
2.	**Do you believe that any part of the reason for the stop or for the extension of your stop by MCSO was because MCSO believed you did not have lawful immigration status in the United States?** ☐ YES ☐ NO
3.	**If you answered yes to question 2, what makes you believe this?**
4.	**If the encounter was a traffic stop, were you the driver?** ☐ YES ☐ NO
5.	**If you answered No to question 4 provide the name of the driver.**
6.	**If the encounter was a traffic stop, please provide the license plate number of the vehicle stopped, and a brief description of the vehicle (if you can):**
7.	**Where did the stop occur? If you do not know the exact location, please provide an approximate location.**
8.	**Reason given by MCSO for stop or extension of your stop (if any).**
9.	**Do you know the badge number(s) of the MCSO deputy or deputies who stopped you?** ☐ YES ☐ NO **If YES, please provide it/them.**
10.	**Were you asked about your citizenship or immigration status during the stop?** ☐ YES ☐ NO
11.	**Who asked you about your citizenship or immigration status?**

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12.	**Were you asked to show any identification documents or immigration papers?** ☐ YES ☐ NO
13.	**Please provide the names and contact information of any witnesses who saw the stop or holding, or who were in the car with you (if known).**
14.	**Please provide any other details about the stop and/or your detention.**

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III. INFORMATION REQUIRED TO RECEIVE ADDITIONAL COMPENSATION FOR OTHER INJURIES

If you are seeking compensation for MCSO detention only and not additional injuries, you may skip this Section. If you wish to receive additional compensation for damages other than for detention by MCSO, such as subsequent detention by federal authorities or for injuries like physical harm, severe emotional distress, or loss of wages or property, please answer the following questions as thoroughly as possible. If you do not have an answer you will not be automatically disqualified from receiving addition money.

A. THE ARREST OR TRANSFER TO IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE)/ CUSTOMS AND BORDER PATROL(CBP)

1.	**Were you arrested or taken from the scene of the stop?** ☐ YES ☐ NO **If YES, what was the stated reason for your arrest?**
2.	**Did ICE/CBP come to the location of the stop?** ☐ YES ☐ NO
3.	**Were you taken to an MCSO jail or facility for any period of time?** ☐ YES ☐ NO **If YES, how long were you kept there?**
4.	**Were you taken in to ICE/CBP custody?** ☐ YES ☐ NO
5.	**In which ICE/CBP detention center were you held (if you know)?**
6.	**How long were you in ICE/CBP custody?**

B. OTHER INJURIES

1. PHYSICAL INJURIES AND/OR EMOTIONAL DISTRESS

a.	**Were you physically injured or did you suffer from severe emotional distress from the stop or detention?** ☐ YES ☐ NO **If YES, please explain:**
b.	**Did you see a doctor for your injuries?** ☐ YES ☐ NO **If YES, please describe the treatment you received:**
c.	**Do you have medical bills that you paid for the treatment described above?** ☐ YES ☐ NO **If YES, what is the total?**
d.	**If you have any documents relevant to your claim for medical expenses (e.g. doctor's bills, pharmacy receipts, receipts), please provide them.**

NOTE: If you are seeking compensation in this program for medical expenses, you must provide your Social Security Number or resident alien number, if you have one. You will not automatically be excluded from compensation for medical expenses if you do not have a Social Security Number or resident alien number.

2. TAKEN PROPERTY

a.	**Please list any property that was taken during the stop or detention, and the approximate monetary value:**

b.	**If you have any documents relevant to your claim for taken property (e.g. receipts, photographs of the property, estimates for comparable replacements), please provide them.**
3. LOST WAGES AND/OR LOST EMPLOYMENT OPPORTUNITIES	
a.	**Did you lose your job as a result of your stop or detention?** ☐ YES ☐ NO
b.	**What job did you lose?**
c.	**Describe your rate(s) of compensation in the job you lost (*e.g.*, "$10 per hour, 8 hours per day, 5 days per week, 50 weeks per year *or* "$20,000 per year").**
d.	**Are you able to provide proof of your wages?** ☐ YES ☐ NO
e.	**When did you lose your job?** --___-__/--____/----_ (month) (day) (year)
f.	**Did you try to find another job?** ☐ YES ☐ NO **If YES, how long did you search for a new job?**
g.	**Did you get another job?** ☐ YES ☐ NO
h.	**If you got another job, when did you get it?** --__-___/--__-__/----__-__ (month) (day) (year)
i.	**If you have any documents relevant to your claim for lost wages and/or lost employment opportunities (e.g. pay stubs, letter of hire, etc.), please provide them.**
4. OTHER PROVABLE HARMS	
a.	**Did you spend money on a lawyer because of your stop or detention other than in connection with the filing and processing of your claim in this program?** ☐ YES ☐ NO **If YES, how much did you pay your lawyer?**
b.	**Did you lose your apartment or house because of your stop or detention?** ☐ YES ☐ NO
c.	**Were you able to secure other housing?** ☐ YES ☐ NO **If YES, how much did this cost as compared to the apartment or house you lost?**
d.	**Are you able to provide proof of your housing costs before and after your stop or detention?** ☐ YES ☐ NO

e.	**Did you incur any other expenses?** ☐ YES ☐ NO **If YES, please detail below:**

Please provide all documentation you may have to verify your stop or detention, injuries or incurred expenses. If you cannot provide any documentation, you may still be eligible for benefits from the Compensation Fund, but you are more likely to receive the highest possible award available to you if you can support your claims with documentation.

IV. CONFIDENTIALITY

All personally identifying information included in the Claim Initiation Form or disclosed through the application process will remain confidential pursuant to a protective order.

V. TAX OBLIGATIONS

The Claims Administrator may issue a Form 1099-Misc as required by the Court Order. Claimants are responsible for any tax reporting responsibilities that arise out of receiving compensation through this program.

VI. RELEASE AND CERTIFICATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all the information provided in this Claim Form is true and correct to the best of my knowledge, information and belief.

I must drop any pending claims against MCSO or Maricopa County for the same harm giving rise to my eligibility in this program.

I understand that I do not have a right to an appeal if my claim in the program is denied, although I may ask for a reconsideration of my claim.

I also understand that by choosing to participate in the Compensation Fund, I cannot sue MCSO or Maricopa County for the same harm giving rise to my eligibility in this program, even if I am not awarded any money as a result of my participation in the Compensation Fund, and I must drop/dismiss any pending claim against MCSO or Maricopa County for the same harm giving rise to my eligibility in this program.

VII. SIGNATURE

Claimant Signature				**Date**	-- _____/--____/----____ (month) (day) (year)
Printed Name	First	MI	Last		
Lawyer Signature				**Date**	-- _____/--____/----____ (month) (day) (year)
Printed Name	First	MI	Last		

VIII. HOW TO SUBMIT THIS CLAIM FORM	
By Mail:	Maricopa County Sheriff's Office Immigration Stops and Detention Compensation Fund P.O. Box 26106 Richmond, VA 23260
By Delivery:	Maricopa County Sheriff's Office Immigration Stops and Detention Compensation Fund c/o BrownGreer PLC 250 Rocketts Way Richmond, VA 23231