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| Legal Assistance Panel Lawyer Application  For a Survivor or Whānau Representation |

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| **Applicant Section** |

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| **Section A**  **Applicant details** | | | | | | | | | | | | |
| **Preferred Title** | | | **First Name** | | | | | | **Middle Name(s)** | | | | |
|  | | |  | | | | | |  | | | | |
| **Last Name** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Other Names Used (First/Middle/Last)** e.g. Mary Sarah Bridges, Sarah Bridges etc. | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Date of Birth** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Postal Address** | | | | | | | | | | | | | |
| Unit/Apartment/Flat Number | | | | | Street Number and Name or P O Box Details | | | | | | | | |
|  | | | | |  | | | | | | | | |
| Suburb | | | | | Town/City | | | | | | Post Code | | |
|  | | | | |  | | | | | |  | | |
| **Phone and Email** | | | | | | | | | | | | | |
| Landline | | | | | Mobile Number | | | | | | Email | | |
|  | | | | |  | | | | | |  | | |
| **My preferred contact method is (Tick 🗸)** | | | | | | | | | | | |
| Mail | |  | Email |  | Landline | |  | Mobile |  | |

**If you would prefer not to answer these questions, please go to page 3**

My Ethnicity / Ethnicities

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If Māori, please advise iwi (if known)

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**Disability**

Leave blank if answer is no

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| --- | --- | --- | --- | --- |
| Do you identify as having a disability or as a disabled person? | Yes |  | Prefer not to say |  |

If yes,

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you have a learning disability / intellectual disability? e.g. I may have trouble following instructions and understanding what is happening | Yes |  | Prefer not to say |  | |
|  |  |  |  |  | |
| Do you identify as being neurodiverse?  e.g. difficulty focusing on a particular issue | Yes |  | Prefer not to say |  | |
|  |  |  |  |  | |
| Do you have a cognitive impairment?  e.g. difficulty understanding or remembering | Yes |  | Prefer not to say |  | |
|  |  |  |  |  | |
| Do you have a physical disability that can impact your decision-making abilities or communication? | Yes |  | Prefer not to say |  | |
|  |  |  |  |  | |
| Do you have a mental health condition that can impact your decision-making abilities? | Yes |  | Prefer not to say |  | |
|  |  |  |  |  | |
| Do you have trauma induced anxiety/stress that can impact your decision making? | Yes |  | Prefer not to say |  | |
|  |  |  |  |  | |
| Are you deaf or hearing impaired? | Yes |  | Prefer not to say |  | |
|  |  |  |  |  | |
| Other (please describe) | | | | | |
| Do you have existing supports? | Yes |  | Prefer Not To Say |  | |
|  |  |  |  |  | |
| If you do not have existing supports, would you like support? | Yes |  | Prefer Not To Say |  | |
| **Section B**  **Legal Assistance eligibility assessment** | | | | |

**Please complete all of the following that apply**

|  |  |
| --- | --- |
| When I was in care, I suffered abuse or neglect |  |
|  |  |
| When whānau or family were in care, they suffered abuse or neglect |  |

The abuse or neglect occurred in the following place(s) or situation(s)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Estimated** | | |  |
| **Place/Situation** | **State Based**  **(🗸)** | **Faith Based**  **(🗸)** | **First Year in Care** | **Last Year in Care** | **Total Years in Care** | **Name of Institution etc.**  **(if known)** | |
| CYFS or Social Welfare placement |  |  |  |  |  |  | |
| Under state supervision at home/with whānau |  |  |  |  |  |  | |
| Foster care placement |  |  |  |  |  |  | |
| Adoption placement |  |  |  |  |  |  | |
| Children's home |  |  |  |  |  |  | |
| Borstal |  |  |  |  |  |  | |
| Psychiatric Care |  |  |  |  |  |  | |
| Disability Care |  |  |  |  |  |  | |
| Health Camp |  |  |  |  |  |  | |
| Early Childhood Educational Facility |  |  |  |  |  |  | |
| School |  |  |  |  |  |  | |

**Continued on next page**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Estimated** | | |  |
| **Place/Situation** | **State Based**  **(🗸)** | **Faith Based**  **(🗸)** | **First Year in Care** | **Last Year in Care** | **Total Years in Care** | **Name of Institution etc.**  **(if known)** | |
| Boarding School |  |  |  |  |  |  | |
| Residential Special School |  |  |  |  |  |  | |
| Regional Health School |  |  |  |  |  |  | |
| Teen Parent Unit |  |  |  |  |  |  | |
| Police or Court Cells |  |  |  |  |  |  | |
| Transport to/between/from Facility |  |  |  |  |  |  | |
| **Other (please list below)** | | | | | | | |
|  |  |  |  |  |  |  | |

**Survivor Applicant - Please go to page 6**

**Whānau or Family Applicant**

Please complete the following for each place/situation you completed above.

If additional space is needed, please use a blank sheet of paper.

|  |  |
| --- | --- |
| **Place/Situation** |  |

The following were abused or neglected in this place/situation

|  |  |  |
| --- | --- | --- |
| **Whānau or Family Member Name** | **Relationship to Applicant** | **Member's Experience**  **e.g. removed from family** |
|  |  |  |
|  |  |  |
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**Please explain why they can't seek Legal Assistance in their own right**

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**If you wish to make a submission etc. for any other reason, please provide a brief explanation below**

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| **Section C**  **Financial eligibility assessment** |

**Please complete all of the following that apply**

**No Income (tick 🗸)**

|  |  |  |  |
| --- | --- | --- | --- |
| In Prison |  | Other (please explain below) |  |

|  |  |
| --- | --- |
|  | |
| **Benefit or Payment Received (tick 🗸)** |

|  |  |  |  |
| --- | --- | --- | --- |
| Jobseeker Support |  | Sole Parent Support |  |
|  |  |  |  |
| NZ Superannuation |  | Supported Living Payment |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ACC Weekly Compensation |  | Other (please describe below) |  |

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**Please go to page 8 if**

* **you have no income**
* **your only income is from one of the above benefits or payments**

**Wages**

|  |  |  |
| --- | --- | --- |
| Average number of hours worked each week |  |  |
|  |  |  |
| Hourly rate before tax deducted |  |  |

**Salary**

|  |  |  |
| --- | --- | --- |
| Annual salary before tax deducted |  |  |

**Self-Employment Drawings**

|  |  |  |
| --- | --- | --- |
| Estimated sum to be drawn this tax year |  |  |

**Seasonal Work**

|  |  |  |
| --- | --- | --- |
| Average number of weeks worked each season |  |  |
|  |  |  |
| Average number of hours worked each week |  |  |
|  |  |  |
| Hourly rate before tax deducted |  |  |

Please explain below how you support yourself off-season e.g. savings etc.

|  |
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|  |

**Please explain below the hardship that would occur if Legal Assistance was declined**

|  |
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| **Section D**  **Nominated lawyer** |

Legal Assistance panel lawyer biographies are available at https://www.abuseincare.org.nz/survivors/legal-assistance/

If you know the panel lawyer you would like as your lawyer, please list their details below.

|  |
| --- |
| **Name** |
|  |
| **Firm/Chambers Name** |
|  |

If you do not know who you want as your lawyer, please tick (🗸) the box below.

|  |  |
| --- | --- |
| Please assign me a lawyer from the Legal Assistance panel. |  |

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| **Section E**  **Applicant confirmation** |

**Important - Read Before Signing**

* The Royal Commission will collect personal information about you to meet its responsibilities under the Inquiries Act 2013, and any other relevant statute or court order; to ensure survivors receive wellbeing support where required; and to assist with demonstrating the depth and breadth of those involved and/or otherwise support the Commissioner’s recommendations.
* This information will be collected and/or viewed by staff of the Royal Commission to complete any tasks assigned to them. No other staff will be allowed to view it.
* Any information used for reporting purposes will not identify you individually.

**By signing this application form, I agree and confirm:**

* Royal Commission staff can
  + Contact me if they have any questions relating to my application for Legal Assistance
  + Advise the relevant wellbeing person/team I have applied for Legal Assistance
  + Contact me if I am not registered with the Inquiry to discuss registering
* I have read and understood the privacy statement set out under: **Important - Read Before Signing**
* I have no other way of paying for legal costs without causing hardship
* I am not aware of any possible conflict of interest that may mean my nominated lawyer should not represent me
* All the information provided in this application is true and accurate to the best of my knowledge and belief

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

If this form will be submitted by email, typing your name in the signature box will be accepted as your signature under the Contract and Commercial Law Act 2017

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| **Lawyer Section** |

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| **Section F**  **Conflict of interest assessment** |

If this form will be submitted by email, typing your name in the signature box will be accepted as your signature under the Contract and Commercial Law Act 2017

I confirm at the time of completing this application there is no known or potential conflict that means I should not represent the applicant.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature |  | | Date |  |
| Please print your name here | |  | | |

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| **Section G**  **What is Legal Assistance wanted for?** |

**Please tick (🗸) those that are known to be required at the time of applying:**

|  |  |  |
| --- | --- | --- |
| To help provide a written statement and/or written submission to the inquiry |  |  |
|  |  |  |
| For representation to attend an inquiry interview (excludes a private session) |  |  |
|  |  |  |
| For representation at procedural and/or public hearings |  |  |

|  |  |  |
| --- | --- | --- |
| Other (please explain below) |  |  |

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**Please explain whether joint representation with participants with a similar situation or facts is appropriate or not.**

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**Please note below anything else the Royal Commission needs to understand when assessing the Legal Assistance funding being requested**

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| **Section H**  **Work to be completed** |

**Please tick (🗸) all of the following that apply at this point in time**

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| --- | --- | --- |
| Activity | Activity Description |  |
| 1 | Completing and filing application for Legal Assistance |  |
| 2 | Preliminary steps |  |
| 3 | Legal Assistance for representation at procedural hearing(s) prior to related public hearing |  |
| 4 | Legal Assistance for representation at interview of possible witness |  |
| 5 | Legal Assistance for person requested by inquiry to provide witness statement or submission |  |
| 6 | Legal Assistance for witness requested to attend inquiry's public hearings and give evidence in person**[[1]](#footnote-1)** |  |
| 7 | Legal Assistance for core participant if granted leave to appear at a public hearing, or requested to do so by the inquiry, including if giving evidence in person or where evidence directly related to the core participant being given |  |
| 8 | Legal Assistance for person to be represented at a public hearing where the Royal Commission believes evidence will be given that daily affects that person |  |
| 9 | Legal Assistance for person **not** requested by inquiry to provide statement, but who wishes to make a submission to Royal Commission including to prepare a statement prior to attending a private session**1** |  |
| 10 | Legal Assistance for a person to be represented at a public hearing where they are required or wish (and have been granted permission) to give evidence to the inquiry remotely e.g. by AVL from prison |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| An interpreter is required to effectively communicate with this client | | | Yes |  | No |  |
|  | | | | | | |
| If yes, type of interpreter required |  |  | | | | |

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| **Section I**  **Travel funding required** |

**Please note:**

Witness travel to a hearing is not covered by Legal Assistance. Please refer to the Witnesses Expense policy. This can be accessed at: https://www.abuseincare.org.nz/public-hearings/about

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is the client based outside your usual work location?** | Yes |  | No |  |
| |  |  | | --- | --- | | If yes, record client location here: |  | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is travel to the client required/likely to be required?** | Yes |  | No |  |

|  |  |
| --- | --- |
| **Section J**  **Form completed by** | |
| **Name** | |
|  | |
| **Postal Address** | |
| Street Number and Name or P O Box Details | |
|  | |
| Suburb | |
|  | |
| Town/City | Post Code |
|  |  |
| **Phone** | |
|  | |

**Application Submission**

Please either

Email to: legalassistance@abuseincare.org.nz

Post to: Abuse in Care Royal Commission

P O Box 10071

Wellington 6140

1. Not applicable to core participants [↑](#footnote-ref-1)