

Request for Taxpayer Identification Number and Certification

Give form to the
requester. Do NOT
send to the IRS.

Name (If a joint account or you changed your name, see **Specific Instructions** on page 2.)
[Redacted]

Business name, if different from above. (See **Specific Instructions** on page 2.)
[Redacted]

COPY

Check appropriate box: Individual/Sole proprietor Corporation Partnership Other

Address (number, street, and apt. or suite no.)
[Redacted]
City, state, and ZIP code
[Redacted]

Requester's name and address (optional)
[Redacted]

List account number(s) here (optional)
[Redacted]

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, if you are a resident alien OR a sole proprietor, see the instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see **How To Get a TIN** on page 2.

Social security number
[Redacted]

OR

Employer identification number
[Redacted]

Part II For Payees Exempt From Backup Withholding (See the instructions on page 2.)

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Part III Certification

Under penalties of perjury, I certify that:
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions.—You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here Signature ▶ [Redacted] Date ▶ 1 / 1 / 01

Purpose of Form.—A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

5. You do not certify your TIN when required. See the Part III instructions on page 2 for details.

Use Form W-9 to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

- 1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
- 2. Certify you are not subject to backup withholding, or
- 3. Claim exemption from backup withholding if you are an exempt payee.

1. You do not furnish your TIN to the requester, or

Penalties

Note: If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

2. The IRS tells the requester that you furnished an incorrect TIN, or

Failure To Furnish TIN.—If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

What Is Backup Withholding?—Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding

3. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

Civil Penalty for False Information With Respect to Withholding.—If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

4. You do not certify to the requester that you are not subject to backup withholding under 3 above (for reportable interest and dividend accounts opened after 1983 only), or

Criminal Penalty for Falsifying Information.—Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs.—If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER 1a. INSURED'S I.D. NUMBER [REDACTED] (FECA PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED] 3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] SEX M F

5. PATIENT'S ADDRESS [REDACTED] 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED] 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO b. AUTO ACCIDENT? YES NO c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED] a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] SEX M F b. EMPLOYER'S NAME OR SCHOOL NAME [REDACTED] c. INSURANCE PLAN NAME OR PROGRAM NAME [REDACTED] d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request that benefits either to myself or to the party who accepts assignment. SIGNED [REDACTED] DATE 1/7/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED [REDACTED]

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY [REDACTED]

16. DATES PATIENT CURRENT OCCUPATION FROM MM DD YY TO MM DD YY [REDACTED]

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE [REDACTED] 17a. I.D. NUMBER OF REFERRING PHYSICIAN [REDACTED]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO \$ CHARGES [REDACTED]

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) [REDACTED]

22. MEDICAID RESUBMISSION CODE [REDACTED] ORIGINAL REF. NO. [REDACTED]

23. PRIOR AUTHORIZATION NUMBER [REDACTED]

24. DATE(S) OF SERVICE	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS CODE	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT OR Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
9:19 00			90806	[REDACTED]	280.-	2	Revisions			
9:26 00			90806	[REDACTED]	280.-					
10:3 00			90806	"	280.-					
10:10 00			90806	"	280.-					
10:17 00			90806	"	280.-					
10:24 00			90806	"	280.-					

25. FEDERAL TAX I.D. NUMBER [REDACTED] SSN EIN 26. PATIENT'S ACCOUNT NO. [REDACTED] 27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) YES NO

28. TOTAL CHARGE \$ 1680 29. AMOUNT PAID \$ 30. BALANCE DUE \$

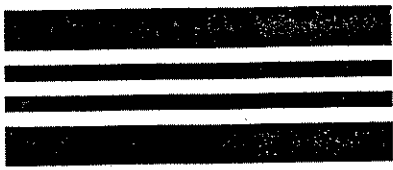
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Edna Moses LCSW SIGNED DATE 1-1-01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) EDNA MOSES 2443-A PORTOLA VENTURA, CA 93003

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Edna Moses 5041 Rocosco Way Santa Barbara CA 93111

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]

3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]

5. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

6. PATIENT STATUS
Single Married Other

7. INSURED'S ADDRESS (No., Street) [REDACTED]

8. PATIENT STATUS
Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. AUTO ACCIDENT? YES NO
c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment below.
SIGNED [REDACTED] DATE 1/2/01

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED [REDACTED]

14. DATE OF CURRENT ILLNESS (MM DD YY) OR INJURY (Accident OR PREGNANCY(LMP)) [REDACTED]

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY [REDACTED]

16. DATES WHEN WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY [REDACTED]

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE [REDACTED]

17a. I.D. NUMBER OF REFERRING PHYSICIAN [REDACTED]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. [REDACTED]

23. PRIOR AUTHORIZATION NUMBER [REDACTED]

PATIENT AND INSURED INFORMATION

24. DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EPSTD Family Plan EMG COB RESERVED FOR LOCAL USE

1	10/31/00				90806		[REDACTED]	280-	2 revisions			
2	11/7/00				90806		[REDACTED]	280-				
3	11/14/00				90806		"	280-				
4	11/21/00				90806		"	280-				
5	11/28/00				90806		"	280-				
6	12/00/00				90806		"	280-				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER [REDACTED] SSN EIN [REDACTED]

26. PATIENT'S ACCOUNT NO. [REDACTED]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE \$ 1680

29. AMOUNT PAID \$

30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED Edna Moses MD DATE 1-1-01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
EDNA MOSES 2943-A PORTOLA VENTURA CA 93003

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Edna Moses
5041 Rocco Way
Santa Barbara CA 93111

DO NOT
APLE IN
IS AREA

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED
OMB NO. 0938-0008

MEDICARE (MEDICARE NO.)
 MEDICAID (MEDICAID NO.)
 CHAMPUS (SPONSOR'S SSN)
 CHAMPVA (VA FILE NO.)
 FECA BLACK LUNG (SSN)
 OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) [REDACTED]

2. PATIENT'S DATE OF BIRTH [REDACTED]

3. INSURED'S NAME (LAST, FIRST, MIDDLE INITIAL) [REDACTED]

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) [REDACTED]

5. PATIENT'S SEX: MALE FEMALE

6. INSURED'S LD. NO. (FOR PROGRAM OR HEALTH PLAN) (INCLUDE ALL LETTERS) [REDACTED]

7. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

8. INSURED'S GROUP NO. (FOR GROUP NAME OR FECA CLAIM NO.) [REDACTED]

9. INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

10. WAS CONDITION RELATED TO:
 A. PATIENT'S EMPLOYMENT: YES NO
 B. ACCIDENT: AUTO OTHER

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) [REDACTED]

12. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDESIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
 SIGNED: [REDACTED] PERSON

PHYSICIAN OR SUPPLIER INFORMATION

13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK-BEFORE SIGNING) [REDACTED] DATE 1/2/00

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) [REDACTED]

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION [REDACTED]

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES [REDACTED]

17. PATIENT ABLE TO RETURN TO WORK [REDACTED]

18. DATES OF TOTAL DISABILITY: FROM [REDACTED] THROUGH [REDACTED]

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY) [REDACTED]

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED [REDACTED] DISCHARGED [REDACTED]

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE) [REDACTED]

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES: [REDACTED]

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE [REDACTED]

24. TABLE:

DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (PROCEDURE CODE IDENTIFY)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. T.O.S.	H. LEAVE BLANK
12/12/00		0	90806	[REDACTED]	290.00			2 22 minutes
1/1/01		"	90906	[REDACTED]	290.00			

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR IDENTICALS) & CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.
 Edna Moses LCSW

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK): YES NO

27. TOTAL CHARGE: 360

28. AMOUNT PAID: 1

29. BALANCE DUE: 1

30. YOUR SOCIAL SECURITY NO. [REDACTED]

31. YOUR EMPLOYER LD. NO. SAME

32. YOUR PATIENT'S ACCOUNT NO. [REDACTED]

33. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.:
 Edna Moses
 5041 Rocco Way
 Santa Barbara CA 93111
 805-683-6702

DIOCESE OF ORANGE



OFFICE OF VICAR GENERAL /
MODERATOR THE CURIA
MARYWOOD CENTER
P.O. BOX 14195
2811 E. VILLA REAL DRIVE
ORANGE, CALIFORNIA 92863-1595
PHONE (714) 282-3000
EMAIL: msgr.jurell@rcbo.org
FAX (714) 282-3029

January 9, 2001

Edna L. Moses, LCSW
5041 Rocoso Way
Santa Barbara, California 93111

COPY

Dear Ms. Moses,

I am in receipt of your letter, with attached billing, regarding your on going work with [REDACTED]. I will be processing your billing for payment by the Diocese; you can look for the check to be coming in the next week or so.

I do have some concerns about the ongoing therapy with [REDACTED]. They are:

- Meeting on a weekly basis for two hours at a time, without a documented treatment program and prognosis, is of concern, as you have not indicated any time limit set for the end of weekly two-hour sessions, nor the actual goal(s) of such therapy.
- The diagnosis of [REDACTED] and your treatment approach of "behavioral therapy" could be at odds with the Catholic Church moral teachings in the way you might suggest that [REDACTED] deal with this issue (which, in itself, if experienced outside of the marriage bond, is contrary to our Church teaching). You also suggest that [REDACTED] "will have to participate in such therapy"; this causes me further concern on the same moral grounds.
- We haven't discussed the testing that you have done in the past to determine the diagnosis of "Post Traumatic Stress Disorder". I note that you have tried to get the materials from Veronica Thomas, Ph.D., for her work with [REDACTED] and are having a difficult time getting it. I am interested in the testing that you have done that has led you to such a conclusion.

There is no doubt in my mind that sexual molestation can and does cause great harm in a victim, and that the issues that must be confronted can take time, sensitivity, and professional assistance. It is the position of the Diocese of Orange that we assist [REDACTED] in coming to resolution and healing for any hurt caused him by (Rev.) Al Ramos.

50600837

At the same time, I must be diligent in my stewardship of Church teachings and morals, as well as the financial resources that are put to the service of those in need. For these reasons, I write my concerns to you.

As of today, the Diocese has paid \$3,920.00 to you for counseling for [REDACTED] we currently owe you a total of \$5,600.00 more for counseling through January 1, 2001. As I stated earlier, I will process those bills for payment.

I am only able to authorize continued counseling assistance in this manner through February 10, 2001. Before I can authorize more financial assistance, an evaluation must be made by the psychological expert used by the Diocese of Orange with regards to your test results, your diagnosis, your treatment plan and your prognosis for [REDACTED] I am certain that you can understand the need for this process at this time.

I request that you send these materials to me and to Kenneth R. Fineman, Ph.D., 17822 Beach Blvd., Suite 437, Huntington Beach, California 92647. Dr. Fineman's phone number is 714 842 9377. Please get [REDACTED] authorization to send the materials to Dr. Fineman.

I am available to speak with you about this matter by phone should you wish. I look forward to hearing from you at your earliest convenience in this matter. I am also available to speak with [REDACTED] should he wish to call me. Finally, you wrote that [REDACTED] lives in Los Angeles; however, the address on the forms you sent me have him living in Brea. I would like to have this point clarified for our files.

With best regards, I am

Sincerely yours in Christ,

COPY

Reverend Monsignor John Urell, V.G.
Vicar General / Moderator of the Curia

C: Kenneth R. Fineman, Ph.D.

50600838

EDNA L. MOSES, LCSW

9-30227-48

Obligation	Description	Invoice	Vendor	Vendor Acct	Amount
27334	CONSULTANT COUNSELING SERVICES *** Total ***		2403		5,600.00 5,600.00

COPY

EDNA L. MOSES, LCSW

9-30227-48

Obligation	Description	Invoice	Vendor	Vendor Acct	Amount
27334	CONSULTANT COUNSELING SERVICES *** Total ***		2403		5,600.00 5,600.00

WARNING: AN ARTIFICIAL WATER MARK - IN A CHIESSCHUSS-PATERN - IS PRESENT ON THE REVERSE SIDE - TO VIEW WATER MARK HOLD AT AN ANGLE.

ROMAN CATHOLIC BISHOP OF ORANGE
A CORPORATION SOLE

2811 E. VILLA REAL DRIVE
ORANGE, CA 92667

BANK OF AMERICA
ORANGE MAIN OFFICE
345 EAST CHAPMAN AVENUE
16-66/1220

30227

DATE

01/19/2001

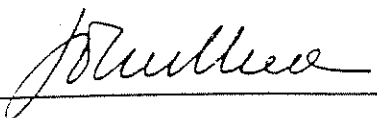
AMOUNT

*****5,600.00

PAY ** Five Thousand Six Hundred Dollars and 00 Cents **

NOT VALID AFTER 6 MONTHS
\$25,000 OR OVER REQUIRES TWO SIGNATURES

TO THE ORDER OF
EDNA L. MOSES, LCSW
5041 ROCOSO WAY
SANTA BARBARA CA 93111



DIOCESE OF ORANGE



OFFICE OF VICAR GENERAL /
MODERATOR THE CURIA
MARYWOOD CENTER
P.O BOX 14195
2811 E. VILLA REAL DRIVE
ORANGE, CALIFORNIA 92863-1595
PHONE (714) 282-3000
EMAIL: msgr.jurell@rcbo.org
FAX (714) 282-3029

February 4, 2001

Edna L. Moses, LCSW
5041 Rocosco Way
Santa Barbara, California 93111

Dear Ms. Moses,

I am writing as a follow up on my letter to you, dated January 9, 2001, in which I expressed some questions and asked for some documentation from you with regards to your professional counseling with [REDACTED]. I am concerned that I have not yet heard back from you (nor has Dr. Ken Fineman) in as much as the last date for counseling for [REDACTED] (paid for by the Diocese of Orange) is scheduled for February 10, 2001. That is, of course, unless our diocesan professional receives the information I asked for and can make a further determination.

I am sending a copy of this letter to [REDACTED] (at the address on the bills you had sent me) in the hopes that he will receive it, and if necessary, he will contact me directly.

I know that you have [REDACTED] best interests at heart; so do I for the Church. I look forward to hearing from you to come to some resolution of these matters.

Sincerely yours in Christ,

COPY

Reverend Monsignor John Urell, V.G.
Vicar General / Moderator of the Curia

C:

[REDACTED]

50600840

Edna Moses.

Ⓞ phone call on 2/9/01.

Ⓞ She never received Jan 9, 2001 letter from me (it was faxed to her on 2/8/01).

Ⓞ The couple ([REDACTED]) is not ~~in therapy~~.

Ⓞ authorization granted through February 2001 -
Ⓞ current rate.

Ⓞ she will send cups requested to Dr Fireman.

[REDACTED] will be calling me.

J. Hall

EDNA L. MOSES LCSW
5041 ROCOSO WAY
SANTA BARBARA, CA. 93111
(805) 683-6702

February 18, 2001

Reverend Monsignor John Urell, V.G.
Vicar General / Moderator of the Curia
Diocese Of Orange County.

Dear Monsignor Urell:

The following is my reply to your letter dated January 9, 2001:

First issue, [REDACTED] diagnosis: [REDACTED]

The DSM-IV suggest diagnosing a patient with this disorder when the following diagnostic criteria are present: A) the person has been exposed to a traumatic event in which both of the following were present:

- 1) The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- 2) The person's response involved intense fear, helplessness, or horror.

In [REDACTED] case, he was about [REDACTED] years old when Rev. Ramos began to molest him for the first time. [REDACTED] trusted Rev. Ramos who was his spiritual and religious leader. [REDACTED] describes experiencing total powerlessness, helplessness, fear and horror that something he felt was totally wrong threatened his body (he was afraid to be raped) and soul, was happening to him. He was fearful that Rev Ramos would injure him, yet, he felt paralyzed to stop it and or ask for help.

B) The traumatic event is persistently reexperienced in one or more of the following ways:

- 1) recurrent distressing recollection of the event, including images, thoughts, or perceptions
- 4) (I selected only the symptoms that apply to [REDACTED]. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- 5) Psychological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Until [REDACTED] he states that he was consumed with memories, flashbacks and terror that he was a "freak", a pedophile and homosexual. While he engaged in sexual relationships he had flashbacks about being molested and he already suffered from sexual dysfunction in previous relationships. When [REDACTED], about five and half years ago, for the first time in his adult life [REDACTED] was symptoms free. Three month later the case of Rev. Ramos was exposed in the newspaper and his sister [REDACTED] asked [REDACTED] while the whole family was present, whether he was one of Rev. Ramos' victims [REDACTED] totally

denied it but subsequently disclosed his molestation by Rev Ramos to his [REDACTED]. Since then, his sexual symptoms and along with that, psychological distress about his sexuality became progressively more and more sever. Every time [REDACTED] is engaged in sexual activity he experiences an intense psychological distress, knowing that he is going to fail and each failure intensifies his distress, and the vicious cycle never ends.

C) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicating by the following: (again, I only selected the symptoms applied to [REDACTED])

- 1) efforts to avoid thoughts, feeling, or conversations associated with the trauma
- 3) inability to recall an important aspect of the trauma
- 6) Markedly diminished interest or participation in significant activities
- 7) Sense of foreshortened future

[REDACTED] exhibits symptoms in all of these categories. He says he pushed the memories down so he could have "normal" life, therefore he says he does not remember everything that happened. He avoids by all cost talking, thinking and feeling associating with the trauma (unless he is in therapy), and he avoids sexual relationship, knowing that he fails each time. It is quite likely that in the in the past, [REDACTED] stayed with [REDACTED] in spite of being emotionally abused by her because he was afraid to start new relationship and fail again. Although [REDACTED] does not exactly have a sense of a forshortened future, perusing a career, marriage and children is greatly compromised. [REDACTED] feels that he is insecure and his insecurity causes a problem in his career as a [REDACTED] as he needs to portray a confident agent. As to getting married and having a family [REDACTED] feels that he needs to resolve his issues, before he makes long-term commitments.

D) Persistent symptoms of increased arousal, as indicated by following:

- 1) Difficulty concentrating

[REDACTED] states he experience a great deal of difficulty concentrating which effects his ability to learn new material and advance in his occupation as a broker.

E) Duration of the disturbance is more than a month. In [REDACTED] case, his symptoms are chronic.

F) The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The problems described above cause [REDACTED] enormous amount of distress and impairment in his ability to maintain normal relationships with women, ability to pursue marriage, major problem with his self esteem (still feels shame and guilt about being molested) and some level of impairment in his occupation.

As to the treatment part: The goal is for [REDACTED] to reach a positive resolution of the trauma. By that I mean, helping [REDACTED] to process the trauma in a realistic way, process the loss elicited by the clear memories of the sexual abuse and internalize a clear understanding that the molestation by Rev. Ramos was not his fault, neither was it his fault for not stopping the molestation.

[REDACTED] will have to be freed from the intense shame that the molestation made him a "freak". He will be able to disclose this "secret" to his family and above all [REDACTED] will no longer unconsciously punish himself by being sexually dysfunctional.

I meet with [REDACTED] once a week for one hour and forty minutes, (clinical session traditionally last fifty minutes). [REDACTED] prognosis is good as he is highly motivated, works

hard in therapy and he has already made considerable progress. As I stated in the past [REDACTED] is a young adult with high level of integrity and in spite of being aware that he can pursue this matter in court, [REDACTED] chooses to resolve his issues in therapy.

Although it is hard to precisely predict how long it will take to reach a successful termination, I hope that in six months [REDACTED] can successfully terminate.

The behavioral therapy was used as an attempt to bypass [REDACTED] emotional issues and relieve him from the symptom that causes him the most distress. This therapy was discontinued as [REDACTED] issues interfered and this method did not lead to any positive results.

Also, [REDACTED] had an appointment with a urologist last year. The urologist prescribed medication, but [REDACTED] refused, saying he did not want to rely on medication for the rest of his life.

I hope my response to your questions is adequate. Please, feel free to contact me, should you have any further questions.

Please keep this letter confidential as it contains sensitive personal issues. I will mail a copy of this letter to Dr. Fineman.

Sincerely,

Edna L. Moses

Edna L. Moses, L.C.S.W.

C: Kenneth R. Fineman, Ph.D.

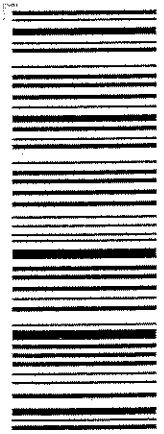
M Edna Moses
5041 Rocosso Way
Santa Barbara CA 93111

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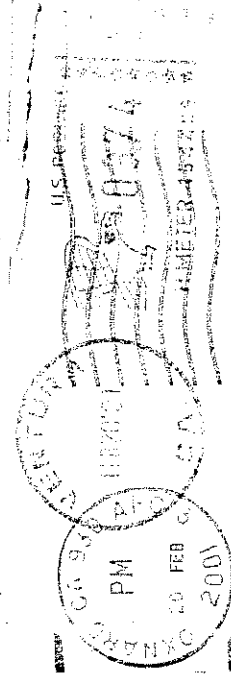
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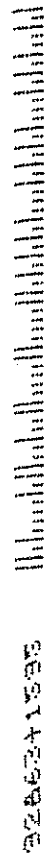
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CERTIFIED MAIL



Reverend Monsignor John Urell, V.C.
Vicar General / Moderator of the Curia
P.O. Box 14195
2881 E. Villa Real Dr.
Orange, CA 92863-1595



DIOCESE OF ORANGE



OFFICE OF VICAR GENERAL /
MODERATOR THE CURIA
MARYWOOD CENTER
P.O BOX 14195
2811 E. VILLA REAL DRIVE
ORANGE, CALIFORNIA 92863-1595
PHONE (714) 282-3000
EMAIL: msgr.jurell@rcbo.org
FAX (714) 282-3029

February 25, 2001

[REDACTED]
[REDACTED]
[REDACTED]
Dear [REDACTED]

I enjoyed our conversation yesterday here at Marywood and I am so pleased that you are moving ahead in your counseling with Edna Moses. It was good to talk with you about your healing and your plans for continued healing in the future. Keep up the good work!

As I also mentioned, Edna is sending Dr. Ken Fineman Ph.D. (our Diocesan specialist) a current evaluation of your progress, her goals for your ongoing therapy, and a proposed timeline for her continued work with you. Once this has been looked at here, then a determination will be made as to the length of time that the Diocese is able to continue to cover your therapy costs. This is standard procedure when determining the work of therapy and the availability of funds to cover such therapy. I hope to have that review done very soon so that your work with Edna Moses can continue.

You remain in my prayers and know that I am available to speak with you as you'd like. The card I gave you has all of my phone numbers and addresses.

With prayerful best wishes to you, I am

Sincerely yours in Christ,

COPY

Reverend Monsignor John Urell, V.G.
Vicar General / Moderator of the Curia

C: Edna Moses
Dr. Ken Fineman, Ph.D.

50600846

PHONE CALL

FOR Moses DATE 2-28-01 TIME _____ A.M. / P.M.

FROM Bob Messer

PH. _____ FAX _____

ME. _____

SIGNED _____

Adams 1154

TELEPHONED
 RETURNED YOUR CALL
 PLEASE CALL
 WILL CALL AGAIN
 CAME TO SEE YOU
 WANTS TO SEE YOU

This was from
a couple
of ~~weeks~~ weeks
ago

Ken Fineman

phone call
3.2.01

- Edna's report is reasonable
- She didn't explain what he is doing now
- What is she doing now ... definite TX plan.
- Ken will write a letter today to Edna Moses asking for TX plans -
- Copy to me.