NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY

VICTIM COMPENSATION APPLICATION

Section 1: VICTIM INFORMATION

Victim information is requested for federal reporting purposes.

Victim Name ______________________________ Victim Date of Birth ______________

Mailing Address ____

City ____________________ State ______ Zip ________ Marital Status ______________

Social Security # (last six digits only) ________ Home Phone ____________ Work Phone ____________

Email ____

Gender Male Female Race ______________________________

Section 2: CLAIMANT INFORMATION

Complete this section if victim is deceased, incompetent, or a minor.

Victim is: ______________________________

Claimant Name ______________________________ Claimant Date of Birth ______________

Mailing Address ____

City ____________________ State ______ Zip ________ Relationship to Victim __________

Social Security # (last six digits only) ________ Home Phone ____________ Work Phone ____________

Section 3: INSURANCE INFORMATION

We are payers of last resort. All bills must first be filed with insurance companies.

Was the victim covered by medicare, medicaid, medical or health insurance? Yes No

Insurance Company ______________________________ Policy # ______________

Address ____

City ______________________________ State ______ Zip ________

Medicaid Number ____________________ Medicare Number ____________________

Brief description of what happened and the injuries sustained: ______________________________

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Section 4: CRIME INFORMATION

Please complete section with all requested information and warrant-based cases must submit a copy of the warrant.

Type of Crime ______________________________

Date of Crime __________ Time ____________ Date Reported __________ Time ____________

Name of Law Enforcement Agency ______________________________ Case # ____________

Location of Crime ____

City ______________________________ County ______________________________

Name of Offender ______________________________ Relationship to Victim ______________

Has case gone to court? Yes No

Was restitution ordered? Yes No Amount $ ______________________________

Warrant # ________ Name of Investigating Officer ______________________________

INJURIES INFORMATION

Continued next page

Did victim receive injuries from the crime? No Yes (describe) ______________________

Did victim receive medical treatment? No Yes (physician) ______________________

Address ______________________________ City __________State ______ Zip ________

Continued

Attach all itemized medical bills related to the injuries received from the crime. If victim is deceased, attach funeral bill and a copy of the death certificate.

Hospital where victim was treated ______________________

Did victim receive counseling? No Yes (counselor) ______________________

Address ______________________ City ____________ State ________ Zip __________

Is victim deceased due to injuries from crime? No Yes

Name of funeral home ______________________ Phone ______________ Federal ID # __________

Address ______________________ City ____________ State ________ Zip __________

Section 5:

TYPES OF ECONOMIC LOSS

Below choose all that apply: victim (v) claimant (c)

Funeral/Burial (v) Lost wages (v) Medical/Dental (v) Mental Counseling (v) Other (v or c)

Was victim employed at time of crime? Yes No (if no, do not compete employment information)

Employer ______________________ Phone ______________

Address ______________________ City ____________ State ________ Zip __________

Section 6:

ADDITIONAL INFORMATION

Supply all additional information as related.

Has an attorney been retained for purposes of representing victim or claimant in a civil suit relate to crime?

Yes No (Attorney name) ______________________

Address ______________________ City ____________ State ________ Zip __________

Was a civil suit filed or do you anticipate filing a civil suit as a result of the crime? Yes No

Have you applied for other financial assistance? Yes No (Agency name) ______________________

Address ______________________ City ____________ State ________ Zip __________

Victim or offender auto insurance ______________________

Address ______________________ City ____________ State ________ Zip __________

Section 7:

CERTIFICATION

Please read carefully, date and sign. Must be 18 or older to sign.

This authorization is granted for a period of two years from this date.

I authorize Victim Compensation Services to request and obtain any information or records required to determine the eligibility of my claim for a period not to exceed the full processing of this application.

I agree that if I recover any money from the offender or from any other source as payment for my injury, I will pay it to Victim Compensation Services or that amount may be deducted from the amount of compensation for which I am eligible.

I agree that the failure to immediately inform Victim Compensation Services of the existence of any other funds constituting payment for my injury may be considered fraud and that Victim Compensation Services may reduce or deny my claim or may initiate an action to recover funds previously paid.

I agree that Victim Compensation Services may pay compensation directly to the provider for any unpaid expenses relating to this claim.

I understand that willfully and knowingly providing false information could result in this claim being disallowed and/or imprisonment of up to five years.

I certify under penalty of law that the information contained in this application is true to the best of my knowledge.

By signing below, you attest that the above information is true and accurate. Further, by signing below you understand and acknowledge that North Carolina General Statute section 15B-7(b) states that a person who knowingly and willfully presents or attempts to present a false or fraudulent, or a State officer or employee who knowingly and willfully participates or assists in the preparation or presentation of a false or fraudulent application is guilty of a Class 1 misdemeanor if the application is for a claim of not more than four hundred dollars ($400.00). If the application is for a claim or more than four hundred dollars ($400.00), the person is guilty of a Class I felony.

Signature ______________________ Printed name ______________________

Date ______________________

Please mail to:

North Carolina Department of Public Safety Victim Compensation Services

4232 Mail Service Center, Raleigh, NC 27699-4232 | Phone: 919-733-7974 | Fax: 919-715-4209 | 1-800-826-6200 (NC)

www.ncdps.gov/dps-services/victim-services