

For Office Use Only

Date Received

VICTIM COMPENSATION APPLICATION

State of North Carolina
Victim and Justice Services

Section 1:
VICTIM INFORMATION

Applicant Name _____ Date of Birth ____/____/____
Last First MI
Mailing Address _____
City _____ State _____ Zip _____ Marital Status _____
Social Security # ____/____/____ Home Phone() _____ Work Phone() _____

CLAIMANT INFORMATION

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

Check One. Victim is: deceased, incompetent, or minor
Claimant Name _____ Date of Birth ____/____/____
Last First MI
Mailing Address _____ City _____ State _____ Zip _____
Social Security # ____/____/____ Relationship of Victim _____
Home Phone () _____ Work Phone () _____

This victim information is requested for federal reporting purposes

GENDER: Male Female **RACE:** Caucasian African American Hispanic American Indian or Alaskan Native Asian or Pacific Islanders

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 what happened and the injuries sustained _____

Section 4:
CRIME INFORMATION

Type of Crime: assault and battery child sexual abuse DUI/DWI
 homicide child physical abuse hit and run
 adult sexual assault domestic assault other _____
Date of Crime ____/____/____ Time: _____ Date Reported ____/____/____ Time: _____
Name of Law Enforcement agency _____ Case # _____
Location of Crime _____ See Incident Report
City _____ County _____
Name of Offender _____ Relationship of Victim _____
Has case gone to court? Yes No Was restitution ordered? Yes No Amount \$ _____
Warrant # _____ Name of Investigating Officer _____

INJURIES INFORMATION Attach all itemized medical and funeral bills related to the injuries received from the crime. Attach a copy of the death certificate .	Did victim receive injuries from the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe _____ Did victim receive medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, physician who treated victim _____ Address _____ City _____ State _____ Zip _____ Hospital where victim was treated _____ Did victim receive counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name of counselor _____ Address _____ City _____ State _____ Zip _____ Is victim deceased due to injuries from crime? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of funeral home _____ Phone # _____ Federal ID# _____ Address _____ City _____ State _____ Zip _____
Section 5: TYPES OF BENEFITS (Check all that apply) COMPLETE THIS SECTION IF VICTIM WAS EMPLOYED AND MISSED WORK.	<input type="checkbox"/> Loss Wages <input type="checkbox"/> Funeral/burial <input type="checkbox"/> Mental Counseling <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Other Was victim employed at time of crime? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, do not complete employment information.) Employer's Name _____ Phone # () _____ Address _____ City _____ State _____ Zip _____
Section 6: ADDITIONAL INFORMATION Supply all additional information as related.	Was a civil suit filed as a result of the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attorney name _____ Address _____ City _____ State _____ Zip _____ Have you applied for other financial assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, agency name _____ Address _____ City _____ State _____ Zip _____ Victim or Offender Auto Insurance _____ Address _____
Section 7: CERTIFICATION Please read carefully, date, and sign. MUST BE 18 OR OLDER TO SIGN. APPLICATION MUST BE NOTARIZED. This authorization is granted for a period of two years from this date.	I authorize the Division of Victim and Justice Services, NC Department of Crime Control and Public Safety to request and obtain any medical or judicial 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 the Division of Victim and Justice Services. I agree that the Commission 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.

STATE OF NORTH CAROLINA

COUNTY OF _____

Sworn to and subscribed before me the undersigned this the

_____ day of _____, _____
 (month) (year)

(Notary Public)

My Commission Expires _____

Dated this the _____ day of _____, _____
 (month) (year)

 Victim (or Claimant's) Signature

 Residence Address

 (City, State, Zip Code)

NORTH CAROLINA DEPARTMENT OF CRIME CONTROL AND PUBLIC SAFETY
CRIME VICTIMS COMPENSATION COMMISSION
 4703 Mail Service Center
 Raleigh, North Carolina 27699-4703
 919-733-7974
 1-800-826-6200
 Web Site: www.nccrimecontrol.org/VJS