

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 \_\_\_\_\_

<b>INJURIES INFORMATION</b>  Attach all <b>itemized</b> medical and funeral bills related to the injuries received from the crime. Attach a copy of the <b>death certificate</b> .	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 _____
<b>Section 5:</b>  <b>TYPES OF BENEFITS</b> (Check all that apply) <b>COMPLETE THIS SECTION IF VICTIM WAS EMPLOYED AND MISSED WORK.</b>	<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 _____
<b>Section 6:</b>  <b>ADDITIONAL INFORMATION</b>  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 _____
<b>Section 7:</b>  <b>CERTIFICATION</b> Please read carefully, date, and sign. <b>MUST BE 18 OR OLDER TO SIGN. APPLICATION MUST BE NOTARIZED.</b> 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](http://www.nccrimecontrol.org/VJS)