VICTIM COMPENSATION APPLICATION

State of North Carolina
Office of Victim Services

Section 1: **VICTIM INFORMATION**	Victim Name____ **Victim** Date of Birth _____/____/____ Last First MI Mailing Address____ City________________________________State_________Zip__________Marital Status____________________ Social Security # (Last 6 digits only) ________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 2: **CLAIMANT INFORMATION** Complete this section if victim is deceased, incompetent, or a minor.	(Check One) Victim is: _______deceased,______incompetent, or ________minor Claimant Name____ Claimant Date of Birth______/_____/______ Last First MI Mailing Address__________________________________City ___________State____ Zip_________ Social Security # (Last 6 digits only)________ Relationship to Victim _____________ 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 :____ ____
Section 4: **CRIME INFORMATION** Please complete section with all requested information. Warrant-Based cases must submit a copy of the warrant.	Type of Crime: _____ assault and battery _____ homicide _____adult sexual assault _____child sexual abuse _____child physical abuse _____domestic assault _____ DUI/DWI _____ hit and run _____ other _________ 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 Attach all **itemized** medical bills related to the injuries received from the crime. If Victim deceased, attach funeral bill and a copy of the **death certificate**.	Did victim receive injuries from the crime? ____No ___Yes – (describe)______________________________ Did victim receive medical treatment? ____No ____Yes - (Physician who treated victim)___________________ Address_______________________________________City_________ State ______Zip________________ Hospital where victim was treated____ Did victim receive counseling? ___No __Yes Name of counselor____ Address__________________________________City____________________State_____Zip____________ Is victim deceased due to injuries from crime ? ____Yes ____No Name of funeral home ___________________________phone #___________ Federal ID# __________________ Street address______________________________City________________State______ Zip ________________
Section 5: **TYPES OF ECONOMIC LOSS** (Check all that apply)	______Lost Wages (Victim) _____Funeral/burial (Victim) _____Mental Counseling (Victim) _____Medical/Dental (Victim) _____Other (Victim or Claimant) Was victim employed at time of crime? ____Yes ____ 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.	Has an attorney been retained for purposes of representing victim or claimant in a civil suit related 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 ________________________
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 year from this date.	I authorize the Office of Victim 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 the Office of Victim 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 the Office of Victim Services of the existence of any other funds constituting payment for my injury may be considered fraud and that the Office of Victim Services may reduce or deny my claim or may initiate an action to recover funds previously paid. I agree that the Office of Victim 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.

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's (or Claimant's) Signature

____
Mailing Address

____
(City, State, Zip)

PLEASE MAIL TO:

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Office of Victim Services
4232 Mail Service Center
Raleigh, North Carolina 27699-4232
(919) 733-7974
1-800-826-6200 (in North Carolina)
Web Address: http://www.nccrimecontrol.org/VJS