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 (select one)

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

Email _____

Gender ○ Male ○ Female Race (select one) _____

Section 2:
CLAIMANT INFORMATION

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

Victim is: _ (select one) _____

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: _____

_____

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 (select one) _____

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 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.

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 Office of Victim 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