



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) divorced married separated single widowed

Cellphone _____ Home Phone _____ Work Phone _____

Email _____ Social Security # (last six digits) _____ Gender Male FemaleRace (select one) African American American Indian or Alaskan Native Asian or Pacific Islanders
 Caucasian Hispanic

Section 2:

**CLAIMANT
INFORMATION**

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

Victim is: (select one) deceased incompetent a minor

Claimant Name _____ Claimant Date of Birth _____

Mailing Address _____

City _____ State _____ Zip _____ Relationship to Victim _____

Cellphone _____ Home Phone _____ Work Phone _____

Email _____ Social Security # (last six digits only) _____

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) adult sexual assault assault and battery child physical abuse
 child sexual abuse domestic assault DUI/DWI pedestrian hit and run homicide 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 _____ Contact number _____

**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

Section 6:

ADDITIONAL INFORMATION

Supply all additional information as related.

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 complete employment information)
Employer _____ Phone _____
Address _____ City _____ State _____ Zip _____
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 1 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 | 1-800-826-6200 | Fax: 919-715-4209
www.ncdps.gov/4victims