Dear Mental Health Care Provider:

A claim for crime victim compensation concerning the above named patient has been filed with the Victims of Crime Compensation Office of the State of New Jersey. Could you please help us process this claim as follows:

- Return to us the completed Psychological Assessment/Authorization form, which is attached to this letter.
- Provide an itemization of your charges. Please note that we are prohibited from paying compensation for missed appointments.

Attached is a copy of the Authorization to Obtain Records and also a copy of our rules governing psychological counseling and our fee schedule.

If you have any questions, please contact the Office at 973-648-2107.

Thank you for your cooperation.

L-7B
RULES GOVERNING PSYCHOLOGICAL COUNSELING

Direct victims:
Psychological counseling shall be compensated as provided by N.J.A.C. 13:75-4.4(b) regarding a direct victim of a crime. A direct victim is a person who was the direct target of the offender's criminal conduct.

For all incidents occurring after October 1, 2003, the maximum amount the Agency shall award for counseling expenses shall be $12,500, notwithstanding the number of counseling sessions attended. For all incidents of crime occurring before October 1, 2003, no more than 100 individual counseling sessions may be authorized to direct victims, minor and adult, in an amount up to $10,000, or for 100 sessions, whichever is greater.

Secondary victims:
A secondary victim is defined as anyone who has sustained an injury or pecuniary loss as a direct result of a crime committed upon any member of the secondary victim’s family or upon any person in close personal relationship to a secondary victim.

A secondary victim or any group of secondary victim’s compensation is limited to $7,000. Included in this maximum is * Family therapy as well as ** Group therapy.

1. Psychological Counseling (CPT 90834 or 90837 covers 45 to 60 minutes)
   Individual counseling for each secondary victim (including family sessions) maximum award $7,000.

   In case of homicides occurring prior to March 6, 2000, the VCCO may authorize an additional 15 sessions for secondary victims.

   For homicides occurring after March 6, 2000, certain family members are to be considered direct victims for counseling purposes and are eligible for $10,000 or 100 counseling sessions, whichever is greater. For homicides occurring on or after October 1, 2003, the maximum was set at $12,500 for direct victims in homicides cases.

2. * Family Group Therapy (CPT 90846 or 90847 – with or without direct victim)
   The VCCO will award compensation for family therapy sessions, sessions wherein the victim and members of the victim’s family are counseled as one.

3. ** Group Therapy (CPT 90853)
   Psychological Counseling for a direct victim and/or secondary victim who is treated in a group setting with other non-related clients. (Direct victim group sessions are applied to the total individual session maximum).
PSYCHOLOGICAL ASSESSMENT/AUTHORIZATION FORM

Claim #: Date form sent:
Victim’s name: Date of incident:
Claimant’s name: Requested by:

SECTION I:

Patient’s name: ________________ Relationship to victim: _________
Name of primary therapist: 
License # and expiration date: ________________ Federal ID#
Credentials: M.D., Ph.D., Psy.D., Ed.D., Ed.S., M.S.W., LSW, A.C.S.W./L.C.S.W.,
L.P.C., M.A., APN

Additional (Specify) __________________________________________________

If patient is not the victim, explain reason for treatment: ______________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

If patient is not the victim, explain reason for treatment:

SECTION II

Initial Treatment Date: __________________________
Diagnosis (DSM V Code and Explanation): ______________________________
____________________________________________________________________
____________________________________________________________________

Indicate relevant social, psychiatric history pertaining to patient and/or the incident:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
The VCCO is able to compensate only for the percentage of therapy expenses which are a direct result of the criminal incident.

Is the victim’s present psychological condition related in whole or in part to the criminal incident?

Yes _____ No _____

If yes, what percentage of treatment deals directly with the psychological trauma of the criminal incident? *(Must be noted in numeric value i.e. 100% - 95% - 90% - 85% etc.)*

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

SECTION III:

Treatment:

[ ] Individual Psychotherapy ____________________ [ ] Grief Counseling
[ ] Group Therapy_____________________________ [ ] Family Counseling
[ ] Other (Specify)

Treatment Plan:

- Treatment Goal:
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________

- Method of accomplishing treatment goals:
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________

- Treatment Session: Please outline the number, frequency, and duration of treatment sessions or programs you anticipate will be required to achieve treatment goals.
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________
Fee per session: ______________________________________

Frequency of sessions - Victim ______________________________________

Frequency of sessions: Other Victims: ______________________________________

Has treatment been terminated?   Yes _____   No _____

Has treatment been deferred until a later time?   Yes _____   No _____

Reason:
____________________________________________________________________

SECTION IV:

Medical Insurance Coverage: (Even if you do not participate with any health insurance carrier [excluding Medicaid and Medicare], if the client has insurance, bills must initially be submitted through insurance before the Office can consider coverage. Failure to comply may result in delay of compensation).

Insurance Carrier(s) ________________________________________________
Policy number (s) ____________________________________________________

Does patient have Medicaid?  Yes____  No _____  Do you accept Medicaid? Yes ____  No _____

=====================================================================

PLEASE SUBMIT A CURRENT ITEMIZED BILL
(Indicate payments made by insurance or the patient)
=====================================================================

SECTION V:

I certify that I am fully licensed in the State Of New Jersey and am not a party in this matter. I certify that all of the foregoing statements and opinions given by me are true and are provided in good faith, in reliance upon such information as has been provided to me. My opinions are based upon my education, training and experience in the Practice of Medicine/ Psychology/ Social Work, and to a reasonable degree of medical/ psychological/ certainty, my opinions reflect accepted standards of practice in my field.

Therapist’s signature: ____________________________________________

Date: ___________________________   Phone #: ______________________

Supervisors’ signature: ________________________________

License # and expiration date:_________________________   Federal ID#:______________

Credentials: M.D., Ph.D., Psy.D., Ed.D., Ed.S., M.S.W., LSW, A.C.S.W./L.C.S.W., LPC, MA, APN
CERTIFICATION FOR RECORDS SUBMITTED TO THE VICTIMS OF CRIME COMPENSATION OFFICE

I hereby certify that the attached records consisting of (ie: medical records of John Doe, police report regarding incident on 1/1/11):

_________________________________________________________________________________________, are true, accurate and complete copies of the original records on file in this office.

I certify that these records were maintained in the regular course of business by (insert name of business/government entity):

____________________________________________________________________________________. I further certify that such records are maintained at or near the time of the relevant event.

I certify that I have knowledge as to the authenticity of these records and that I have the responsibility of maintaining their custody.

I certify that the foregoing statements made by me are true and correct to the best of my knowledge. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to punishment.

__________________________________________  ________________
Date:                                           Signature:

_____________________________________________
Print name:

_____________________________________________
Title or Position: