



PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

State of New Jersey
OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CRIMINAL JUSTICE
VICTIMS OF CRIME COMPENSATION OFFICE

50 Park Place
Newark, NJ 07102
Telephone: (973) 648-2107 Fax: (973) 648-3937
Website: www.njvictims.org Email: njvictims@njvictims.org

MATTHEW J. PLATKIN
Acting Attorney General

LYNDSAY V. RUOTOLO
Director

MARY ELLEN BONSPER
VCCO Director

Re: Patient:
Claim#:
Investigator:
Telephone:
Account #:

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).**

RETURN THIS FORM TO: Victims of Crime Compensation Office
50 Park Place
Newark, NJ 07102

PSYCHOLOGICAL ASSESSMENT/AUTHORIZATION FORM

Claim #:
Victim's name:
Claimant's name:

Date form sent:
Date of incident:
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:

- | | |
|---|--|
| <input type="checkbox"/> Individual Psychotherapy _____ | <input type="checkbox"/> Grief Counseling |
| <input type="checkbox"/> Group Therapy _____ | <input type="checkbox"/> Family Counseling |
| <input type="checkbox"/> 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

Date: _____

Phone # : _____

**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: _____