



**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 VIOLENCE INTERVENTION AND VICTIM ASSISTANCE**  
**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**  
*Attorney General*

**PATRICIA TEFFENHART**  
*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:

1. Completed Psychological Assessment/Authorization form, which is attached to this letter.
2. 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 Record a copy of our fee schedule and the maximum counseling allowance.

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

Thank you for your cooperation.

Sincerely,

L-7B

## VCCO Counseling Fee Schedule

| Credentials                              | Fee   | Details   |
|--|---|---|
| Psychiatrist                             | \$150 per hourly session                      |   |
| Mental Health Practitioner (Unlicensed)  | \$110 per hourly session                      | Practicing in compliance with N.J.S.A. 45:14B-6 (Psy.D., Ph.D., Ed.D.)                                |
| State Licensed Psychologist              | \$110 per hourly session                      |   |
| L.P.C, L.C.S.W., A.C.S.W., A.P.N., Ed.S. | \$90 per hourly session                       |   |
| Licensed Marriage & Family Therapist     | \$90 per hourly session                       |   |
| M.S.W.                                   | \$80 per hourly session                       | Jurisdictions other than New Jersey or in New Jersey practicing in compliance with N.J.S.A. 45:14B-6. |
| M.A.                                     | \$80 per hourly session                       | Jurisdictions other than New Jersey or in New Jersey practicing in compliance with N.J.S.A. 45:14B-6. |
| Group counseling sessions                | \$50 per eligible claimant per hourly session | Sessions involving three or more individuals conducted by any of the above credentialed providers     |

### Maximum allowance

(\*-Effective February 5, 2018)

|   | Maximum Allowance |
|---|-------------------|
| Direct victim                                 | \$20,000*         |
| Surviving family member in a homicide         | \$20,000*         |
| Secondary victims (including family sessions) | \$7,000           |

**RETURN THIS FORM TO:**      **Victims of Crime Compensation Office**  
**Email: njvictims@njvictims.org**  
**Fax: 973-648-3937**  
**Mail: VCCO, 50 Park Place, Newark, N.J. 07102**

**PSYCHOLOGICAL ASSESSMENT**

Claim #: \_\_\_\_\_ Date form sent: \_\_\_\_\_  
Victim's name: \_\_\_\_\_ Date of incident: \_\_\_\_\_  
Claimant's name: \_\_\_\_\_ Requested by: \_\_\_\_\_

**SECTION I:**

Patient's name: \_\_\_\_\_ Patient 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 (Jurisdictions other than New Jersey or in New Jersey clinicians practicing in  
compliance with N.J.S.A. 45:14B-6.)

Additional (Specify) \_\_\_\_\_

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

**SECTION II**

Initial Treatment Date: \_\_\_\_\_

Please specify if sessions were in-person or telehealth: \_\_\_\_\_

Please describe the crime(s) for which you are providing treatment including relevant  
details provided to you:  
\_\_\_\_\_  
\_\_\_\_\_

If the victimization occurred longer than five years ago or there was a break in treatment of one year or longer, describe the events, behaviors, or reasons the claimant has sought treatment at this time:

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Diagnosis (DSM 5 Code and Explanation including any other conditions that may be the focus of clinical attention):

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Principal Diagnosis: \_\_\_\_\_ Additional Diagnoses: \_\_\_\_\_

Indicate relevant social, psychiatric history pertaining to patient and/or the incident:

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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.)**

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**Please note: The VCCO can only pay for the percentage of treatment that is necessary as a direct result of the crime for which the application was filed.**

**SECTION III:**

Treatment:

- Individual Psychotherapy \_\_\_\_\_
- Group Therapy \_\_\_\_\_
- Other (Specify) \_\_\_\_\_

- Grief Counseling
- Family Counseling

Treatment Plan:

1. Treatment Goal:

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2. Method of accomplishing treatment goals:

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3. Treatment Session: Please outline the number, frequency, and duration of treatment sessions or programs you anticipate will be required to achieve treatment goals.

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Fee per session: \_\_\_\_\_

Frequency of sessions – Victim \_\_\_\_\_

Frequency of sessions: Other patient: \_\_\_\_\_

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 \_\_\_

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**PLEASE SUBMIT A CURRENT ITEMIZED BILL WITH THE CORRESPONDING  
INSURANCE EXPLANATION OF BENEFITS AND THE COMPLETED  
PSYCHOLOGICAL ASSESSMENT FORM TO:**

**Victims of Crime Compensation Office**  
**Email: njvictims@njvictims.org**  
**Fax: 973-648-3937**  
**Mail: VCCO, 50 Park Place, Newark, N.J. 07102**

Please include the VCCO claim # at the top of your bill. The bill should include the patient's name, dates of services, CPT codes, total charges and any payments made by insurance or the patient.

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**Please note: Pursuant to N.J.A.C. 13:75-4.4(c) A medical, mental health, counseling, or other provider who accepts payment from the Office shall accept the Office's rate as the maximum allowable payment for that service and shall not seek or accept further payment from any other source if the total of payments accepted would exceed the maximum rate set by the Office for that service. This caveat does not apply to clients whose treatment is determined to be less than 100% related to the incident the VCCO petition is based.**

**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 #: \_\_\_\_\_

Email address: \_\_\_\_\_

(When applicable) Supervisors' credentials and signature: \_\_\_\_\_

License # and expiration date: \_\_\_\_\_ Federal ID#: \_\_\_\_\_

Date: \_\_\_\_\_ Phone # : \_\_\_\_\_