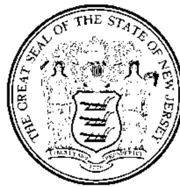

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
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
Executive 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 #:
Victim's name:
Claimant's name:

Date form sent:
Date of incident:
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:

___
___
___

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

___
___
___
___

Principal Diagnosis: ________________ Additional Diagnoses: ______________

Indicate relevant social, psychiatric history pertaining to patient and/or the 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.)**

___

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:

____
____
____

2. Method of accomplishing treatment goals:

____
____
____

3. 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 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 ____

==

PLEASE SUBMIT A CURRENT ITEMIZED BILL WITH THE CORRESPONDING INSURANCE EXPANATION 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.

==

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 # : _______________________