

Provider Information

Name: _____
Address: _____
Telephone Number: _____ License/Certification Number: _____
Supervisor: _____ Supervisor License Number: _____
Are you a Medicaid provider? No ___ Yes ___ If yes, types: _____
Is the victim in DCF custody? No ___ Yes _____

Client Information

Client Name: _____ Victim Name: _____
Does the client have insurance? No ___ Yes ___ Insurance Carrier Name: _____
Does the client have Medicaid? No ___ Yes ___
Are you presently billing Medicaid for these services? No ___ Yes ___
If you are not billing client's insurance, please explain _____

Type of crime: **sexual assault** _____ **domestic violence** _____ **child sexual abuse** _____ **assault** _____
child physical abuse _____ **homicide** _____ **other (please list)** _____

Date of crime: _____
Suspect: _____
Status of criminal proceedings: _____

Treatment Information

Individual/Family Counseling _____ Group Counseling _____

Diagnosis: _____

Please briefly describe the client's symptoms related to the crime:

What are the goals of the treatment:

- 1.
- 2.
- 3.

Date of first session: _____

Based on the crime-related symptoms presented, what is the estimated number of sessions for this treatment? _____

Provider Agreement

I certify that the treatment being billed to the Victims Compensation Program for the above-named client focuses directly on the crime mentioned above, and is trauma/crisis oriented. I have read the Mental Health Policy and Payment Policy and agree to abide by the conditions in these policies.

I understand that if I am receiving payment through any grant, contract, funding source, or if I am a salaried employee through another agency that is paying for my services, I cannot bill the Victims Compensation Program for the same services.

I also understand that the Victims Compensation Program is last payer, and acknowledge that I must bill the client's insurance first, unless otherwise agreed upon with the Victims Compensation Program.

I agree to inform the Victims Compensation Program immediately in writing when charges have been filed against me by the Office of Professional Regulation. I must also notify the Program if my license or roster becomes inactive, revoked, or conditioned in the state in which I practice.

Provider Signature

Date