

**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 the 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