

**PROVIDER INSTRUCTIONS
RENEWAL REQUEST FOR MENTAL HEALTH SERVICES**

Mental health therapy for crime victims is an area of specialization within the mental health field and must be problem/crime specific. It requires particular training and clinical experience. Therapists must be licensed and meet requirements in WI Administrative Rule JUS 11.06. Requests for reimbursement by the Program must be in itemized form. Eligible providers of mental health treatment include:

- a) a licensed physician who has completed a residency in psychiatry;
- b) a licensed psychologist who is licensed or eligible to be listed in the National Register of Health Service Providers in Psychology;
- c) a person with a masters degree who is certified eligible as a psychotherapy provider under the medical assistance program, if providing services under the supervision of a licensed psychologist or psychiatrist certified as a psychotherapy provider under the WI medical assistance program;
- c) a crisis counselor employed by a recognized crisis counseling agency who works under the supervision of a licensed psychologist or psychiatrist certified as a psychotherapy provider under the WI medical assistance program.

The Crime Victim Compensation Program can not guarantee payment of bills. The program must review pertinent documentation before a payment decision can be made.

If there are any other sources to pay for this victim's/survivor's therapy expenses, such as insurance, Medical Assistance, Medicare, the bills **must** be submitted to that source **first**. **The Crime victim Compensation Program will only consider payment of a bill after it has been processed by any other available source. Therapists must be certain to ask their clients if they have a source available to provide or pay therapy. If this program determines that a claimant had a collateral source that would have covered the charges but chose to receive treatment by a provider not covered by that source, the payment may be denied by this program.** Even if the patient advises you that this program will cover the charges, you should verify that information with this program.

If the victim/claimant is eligible for a sliding fee scale, the provider must bill the Program no more than the sliding fee scale.

The Program cannot **cover**:

| | |
|--|-----------------------------------|
| missed appointments | sessions with the offender |
| court appearances | travel time |
| advocacy functions | interest on charges |
| report writing | case management |
| telephone counseling | criminal investigative procedures |
| counseling for issue not directly related to the crime | |

YOU MUST BILL YOUR CLIENT. This is done because your client may be responsible for all or a portion of their bills. If you wish to expedite this claim, you may send duplicate copies of the itemized bills that are sent to the claimant, along with copies of the corresponding insurance explanation of benefit forms, to the address below:

**Crime Victim Compensation Program
PO Box 7951
Madison, WI 53707-7951**

If you have any questions please call 608-264-9497 and ask to speak with the Claims Specialist handling this claim.

RENEWAL REQUEST FOR MENTAL HEALTH SERVICES

CLAIM #: _____

MENTAL HEALTH THERAPY PROVIDER INFORMATION

Therapist Name & Title:

Telephone:

Federal Tax ID Number:

Agency Name & Address:

License Number:

SECTION I: VICTIM/SURVIVOR INFORMATION

Name:

D.O.B.:

Address:

Date Entered Treatment:

Frequency of Treatment Sessions:

Health Insurance Carrier:

Number of Sessions to Date:

Please describe symptoms for which the victim/survivor is seeking treatment. List any new events in the victim/survivor's life since treatment began that are impeding treatment progress.

SECTION II: VICTIM/SURVIVOR TREATMENT ISSUES

Please summarize progress toward treatment goals since last report.

Please list any pre-existing mental health issues affected or discovered due to the crime against the victim. If your treatment focus includes conditions that occurred prior to the crime but are exacerbated by the crime, please describe those conditions, the way they are exacerbated and how they'll be addressed. (Note: After the initial phase of treatment, continuing treatment of pre-existing conditions can limit your reimbursement if it is determined that such treatment is not necessary for the victim's coping related to the qualifying crime.)

Percentage of treatment time spent treating the pre-existing condition: _____ %

In the past 3 months, has this victim exhibited any of the following symptoms at a level that you consider clinically significant? Check all that apply:

| | | |
|----------------------------|-------------------------|--------------------------------|
| Aggression | Dissociation | Obsessive Behavior |
| Anger | Emotional numbing | Panic |
| Anger | Fear | Phobias |
| Apathy | Flashbacks | Self-blame |
| Avoidance | Guilt | Self-destructive Relationships |
| Behavior Problems | Harm/threats to others | Self-harm/behavior |
| Compulsive Behavior | Hyperactivity | Sexual Acting Out |
| Crying | Hyperarousal | Sexual Dysfunction |
| Denial | Insomnia/sleep Problems | Somatic Complaints |
| Depression | Irritability | Substance Abuse |
| Difficulty Concentrating | Memory Problems | Substance Abuse Withdrawal |
| Disordered Eating Symptoms | Nightmares | Other |

Please state your goals for the next 6 months of treatment and how you hope to accomplish these goals using objective and measurable goals.

Medications and dosages currently prescribed that have changed since the first report (please **circle** those directly related to crime):

Is the victim/survivor disabled from working due to the mental health condition **directly** related to the crime?
 Yes ___ No ___ If yes, provide the date disability began and the victim/survivor is able to return to work: _____

Based on the information presently available, please rate the victim's prognosis for resolution of the crime related concern for which you were consulted:

| | | | |
|-----------|------|------|------|
| Excellent | Good | Fair | Poor |
|-----------|------|------|------|

Frequency of therapeutic contacts: _____ Anticipated date of termination: _____

Circumstances that would extend or shorten the period until termination date:

SECTION III: OTHER PERTINENT INFORMATION

Please add additional information not in the assessment and treatment plan if necessary. If more space is needed, attach a separate document to this plan.

SECTION IV: SIGNATURE

The information contained herein is correct to the best of my knowledge, information and belief. I understand and agree to the following:

1. I meet the requirements as listed in Wisconsin Rule JUS 11.06;
2. Under the statutes and rules applicable to the Crime Victim Compensation Program as the payer of last resort, I agree to apply for any insurance benefits of the victim, including, but not limited to, Medicaid/Medicare, to which the victim may be entitled and I agree to apply the sliding fee scale that would be billed to the victim in billing the Crime Victim Compensation Program;
3. I will cooperate with the Program for requests for information needed to determine initial and continuing eligibility for the Program.

 Therapist's Signature

 Date

