MENTAL HEALTH EXPENSES

The following must be included in order to file a claim for mental health counseling payments(s) or reimbursement:

1. Claim Form for Mental Health Expenses.
2. Invoice from the mental health provider listing dates of services, mental health codes, and cost per session.
3. Mental Health Initial Treatment Plan or Mental Health Treatment Update (if one is due).
4. Mental health treatment must be for issues related to the victimization.
5. See Mental Health Treatment Provider Information for additional information.

Louisiana Crime Victims Reparations Board
MENTAL HEALTH TREATMENT
Provider Information

Compensation for mental health expenses is subject to the timely and accurate filing of required documents. Delays in filing may result in delays in compensation.

Treatment Plans & Reviews:

a) **Mental Health Treatment Initial Plan**-This form must be completed by each therapist and submitted to either the claim investigator at the Sheriff's office of jurisdiction, or the Louisiana Crime Victim's Reparations Board (CVRB). This form should be submitted within 3 months of treatment onset and should indicate the relationship between the victim's symptoms and treatment, and the experience of the reported crime.
b) **Mental Health Treatment Update**- This form must be completed by each therapist and submitted every 6 months during the life of the case. Cases that temporarily cease treatment and later return should have an immediate treatment update submitted if it has been longer than 6 months since the last update was submitted.
c) **Mental Health Treatment Review**- Depending upon the nature of the crime, many victims will evidence reasonable stabilization following six months to a year of continuous care. Cases that fail to show reasonable stabilization during this time period may be subject to review in order to be eligible for continued compensation.

Reimbursement Rates & Limits:

a) Current reimbursement rates are **$110 per session** for doctoral-level therapists (psychologists, psychiatrists, and other qualified M.D.s), **$90 per session** for masters-level therapists (e.g., LCSW, LPC, LMFT), and **$50 per group** for group therapy. Only physicians, psychiatrists, state-certified or state-licensed psychologists, licensed professional counselors, or board-certified social workers are eligible for reimbursement.
b) Claimants are eligible for up to **$2,500.00** in outpatient mental health services for the life of the case. Application for extended outpatient mental health compensation of up to **an additional $2,500.00** is available, but is subject to review. Based upon research related to the treatment outcome of trauma-related conditions, it is anticipated that the majority of victims will achieve reasonable stabilization within 6 months of viable treatment. Therefore, applications for extended treatment will be carefully reviewed for medical and/ or clinical necessity, as well as the efficacy of past and proposed treatment by the provider.

Payments & Expense Verification:

a) **NOTE: IF YOU ARE THE VICTIM OF A SEXUALLY ORIENTED CRIMINAL OFFENSE, YOU ARE NOT REQUIRED TO FILE WITH YOUR INSURANCE IN ORDER TO RECEIVE ASSISTANCE FROM CRIME VICTIMS REPARATIONS. However, if you do choose to file with your insurance, the insurance information must be completely filled out on the Mental Health Expenses Claim Form.**
b) Reimbursements from the CVRB are made after all other sources of payment are utilized. When insurance is available, evidence must be provided that insurance has been processed and applied accordingly (this includes out-of-network benefits). The therapist should clearly indicate when there are no insurance or other third-party payers available for compensation.
c) The board has no contract with providers and does not stipulate "allowable" charges. However, the CVRB will only reimburse the difference between the total amount of third-party payers available for compensation.

Eligible Claimants:

a) **Primary Victim**- any individual directly victimized by a criminal activity.
b) **Secondary Victim**- for any surviving family member of a homicide victim or any person in close relationship to such victim. A parent or sibling of a child sexual abuse victim may also qualify as a secondary victim.

CLAIM FORM FOR MENTAL HEALTH EXPENSES

THIS FORM IS TO BE COMPLETED BY THE CLAIMANT

CVR NUMBER: _____ Victim Name: _____

Claimant Name: _____

Your claim investigator is: _____ Phone: _____

NOTE: Neither the CVR Board nor the Sheriff's office is responsible for your bills.

Neither the Board nor the Sheriff's office is to be listed as the guarantor on the invoice or statement.

STEP 1. ANSWER THESE QUESTIONS ABOUT YOUR EXPENSES.

1. A. Are you responsible for any of these bills? [ ] Yes [ ] No, then who?_____
   B. If not, have you paid all or part of them anyway? [ ] Yes [ ] No
   NOTE: If you answered NO to questions 1A or 1B; stop here. You cannot submit a claim for this expense.
   If you answered YES to either question, please continue.
2. Complete the following information for all insurance and/or benefit (**including Medicare**) plans **which might cover these expenses**. If you have no insurance, please write "**None**" for company name.

Company Name _____ Phone _____

Policy Number _____ Group Number _____

Address _____
(Street, City, State, & Zip Code)

STEP 2. LIST ALL EXPENSES. Include **current itemized** bills from the mental health provider. Do **not** include bills paid-in-full by an insurance company.

Provider Name	Total Bill +	Ins. Pmts/Ins. Adj., Other Pmts. -	Amount paid by Claimant -	Amount Owed to Providers =

YOU MUST ATTACH A COPY OF THE ITEMIZED BILL **AND** INSURANCE SETTLEMENT FOR EACH EXPENSE CLAIMED.

FOR MEDICAL MILEAGE: Identify Mental Health Provider, dates of visits, miles round trip. The dates listed below must correspond with the documentation listed above. Only claim trips of 20 or more miles one-way for reimbursement.

NAME OF MEDICAL PROVIDER	DATES OF VISIT(s)	MILES/ROUND TRIP

STEP 3.

CLAIMANT SIGNATURE _____ **DATE** _____

SEND THIS FORM AND REQUIRED ATTACHMENTS TO YOUR CLAIM INVESTIGATOR.

Revised: October 28, 2014

Louisiana Crime Victims Reparations Board

Mental Health Treatment - INITIAL PLAN

[Confidential under L.R.S. 46:1806(C)(2)]

THIS FORM IS TO BE COMPLETED BY THERAPIST WITHIN THE FIRST 4 WEEKS OF TREATMENT

CVR NUMBER:_____

VICTIM NAME:_____

CLAIMANT NAME:_____

ADDRESS:_____

_____

VICTIM SSN:_____

DATE OF CRIME:_____

CLAIMANT INSTRUCTIONS:

1) Give this form to the therapist to complete and ask that it be returned, along with itemized bills, to you or the claims investigator in your local Sheriff's Office.

2) Attach the completed form to your claim.

PROVIDER INSTRUCTIONS:

1) Complete BOTH PAGES of this form and return, along with itemized bills, to the claimant or the claims investigator in your local Sheriff's Office.

2) If insurance is available and is being used, it must be processed and declared before seeking compensation from CVR. This includes use of Medicare, Medicaid, or any other government source of funding for services such as state or federal grants. Submission of EOBs is recommended.

3) If insurance, Medicare, or Medicaid is available but is not being processed because you are not a contracted provider, please indicate this clearly in the space for insurance below.

4) **Please note that the CVR is a 3rd party payer of last resort and may be able to help victims with crime-related expenses such as mental health counseling. **However, the CVR is NOT to be considered a guarantor for any services provided, and should never be listed as the entity responsible for payment on any invoicing.****

DESCRIBE CLINICAL SYMPTOMS/DIAGNOSIS RELATED TO CRIME:_____

_____

LIST PRIOR DIAGNOSES/TREATMENT:_____

_____

DSM-V DIAGNOSES:

DATE TREATMENT BEGAN:_____/_____/_____ ESTIMATED RESOLUTION DATE:_____/_____/_____

IF INSURANCE IS AVAILABLE IT MUST BE FILED FIRST

INSURANCE NAME:_____ POLICY NO_____

ADDRESS_____

CITY_____ ST_____ ZIP_____ PHONE (_____)_____

CERTIFICATION: *Have you received any federal funds to provide services (i.e., VOCA, VAWA grants)?* ( ) Yes ( ) No

SIGNATURE OF LICENSED PROVIDER	TERMINAL DEGREE	LICENSE NO.
PRINTED NAME	TELEPHONE NO.	DATE
ADDRESS	CITY	ST ZIP

COMPLETE PAGE 2 ALSO

Mental Health Treatment - INITIAL PLAN

Patient Name_____

1) List targeted problem areas that are **related to the victimization**.
2) For each problem area, list specific goals of treatment.
3) Describe how treatment goals will be accomplished via treatment interventions.
4) For each problem area, list an estimated resolution date. **(Please note that a different form, the TREATMENT UPDATE FORM, will be required after 6 months.**

Problem Areas	Treatment Goals	Interventions	Est. Resolution Date

Louisiana Crime Victims Reparations Board

Mental Health Tretment – UPDATE FORM

[Confidential under L.R.S. 46:1806(C)(2)]

PLEASE NOTE: Completion of this form is required to show the necessity of continued treatment, and should be completed after the first 6 months of treatment and every 6 months thereafter.

While many victims may benefit from long-term therapy, the Crime Victims Reparations Board is able to provide compensation only for therapy that is necessary to reduce significant risk to a victim and/or restore a victim to a reasonable level of functioning. This may or may not be a level that is equal to the victim's functioning prior to the crime.

IDENTIFYING INFORMATION:

Victim Name:_____ Soc. Sec. No:_____

Claimant Name:_____ Date of Crime:_____

Therapist Name:_____ Claim No:_____

Therapist Signature:_____ Date:_____

Therapist Federal Employer Identification Number:_____

DSM-V DIAGNOSES:

_____

_____

_____

FUNCTIONAL IMPAIRMENTS:

(Rate the severity of impairment in each area below, and describe how the above symptoms impair functioning or place the victim at risk)

1 = MILD (impacts quality of life but no significant impairment of day to day functioning)

2 = MODERATE (significant impact on quality of life and/or day to day functioning)

3 = SEVERE (profound impact on quality of life and day to day functioning)

AREA	SEVERITY	DESCRIPTION
Job/School	_____	_____
Relationships/Family	_____	_____
Other_____	_____	_____

SYMPTOMS & PROBLEMS:

(Check all that substantiate Axis I & II diagnoses and rate the severity of each)

1 = MILD (impacts quality of life but no significant impairment of day to day functioning)

2 = MODERATE (significant impact on quality of life and/or day to day functioning)

3 = SEVERE (profound impact on quality of life and day to day functioning)

❑	Anxiety	1	2	3	❑	Irritability	1	2	3	❑	Lability	1	2	3
❑	Appetite Disturbance	1	2	3	❑	Independent Living Problems	1	2	3	❑	Bingeing/Purging	1	2	3
❑	Bizarre Behavior	1	2	3	❑	Poor Interpersonal Skills	1	2	3	❑	Laxative/ Diuretic Abuse	1	2	3
❑	Conduct Problems	1	2	3	❑	Poor Judgment	1	2	3	❑	Anorexia	1	2	3
❑	Depressed Mood	1	2	3	❑	Impaired Memory	1	2	3	❑	Circumstantial/ Tangential	1	2	3
❑	Gender Issues	1	2	3	❑	Obsessions/ Compulsions	1	2	3	❑	Loose Associations	1	2	3
❑	Bizarre Ideation	1	2	3	❑	Panic Attacks	1	2	3	❑	Delusions	1	2	3
❑	Low Energy/ Anhedonia	1	2	3	❑	Paranoid Ideation	1	2	3	❑	Hallucinations	1	2	3
❑	Psychomotor Retardation	1	2	3	❑	Phobia	1	2	3	❑	Aggressive Behaviors	1	2	3
❑	Poor Concentration	1	2	3	❑	Sexual Dysfunction	1	2	3	❑	Oppositional Behavior	1	2	3
❑	Agitation	1	2	3	❑	Sleep Disturbance	1	2	3	❑	Other			
❑	Elimination Disturbance	1	2	3	❑	Somatization	1	2	3	_____		1	2	3
										_____		1	2	3

CURRENT RISK FACTORS:

SUICIDALITY: ❑ None ❑ Ideation ❑ Plan ❑ Intent w/o means ❑ Intent with means

HOMOCIDALITY: ❑ None ❑ Ideation ❑ Plan ❑ Intent w/o means ❑ Intent with means

IMPULSE CONTROL: ❑ Sufficient ❑ Moderate ❑ Minimal ❑ Inconsistent ❑ Explosive

MEDICAL RISKS: ❑ Yes ❑ No If Yes, explain_____

OTHER:_____

TREATMENT GOALS:

(List specific goals directed at reducing risk and impairment to functioning specified above. Also rate the progress toward meeting each goal using the scale below)

N – NEW GOAL

1 – MUCH WORSE

2 – SOMEWHAT WORSE

3 – NO CHANGE

4 – SLIGHT IMPROVEMENT

5 – GREAT IMPROVEMENT

R – RESOLVED

Treatment Goals	Treatment Methods	Progress (since last report)	Expected Resolution Date

Claimant Signature

Date