



PAYMENTS AND REIMBURSEMENTS AT A GLANCE & SUPPLEMENTAL FORMS

IF: You are requesting assistance with	THEN: You will need to provide
<p>Crime Related Medical/Dental/Optical Expenses</p> <p>For payments to the providers or reimbursements to victims: one or more of the following will be required for all separate crime related dates of service.</p> <p>SOVA pays the outstanding balance for compensable bills not fully covered by existing medical/dental insurance. If a victim has private or public medical/dental insurance, bills must first be filed with applicable companies/carriers before submission to SOVA for possible payment/reimbursement.</p> <p><i>NOTE: SOVA pays after health and dental insurance</i></p>	<ul style="list-style-type: none"> • UB-04 Medical Claim Form (from your provider) • UB-92 Medical Claim Form (from your provider) • Health Insurance Medical Claim form (CMS-1500) (HCFA-1500) (from your provider) • Itemized bill of charges from medical provider • ADA Dental Claim Form (w/treatment plan) (certificate of medical necessity might be required) • Itemized bill from vision center for eyeglasses • EOB (Explanation of Benefit from Health/Dental insurance company)(Health/Dental/Medicaid must be filed first if a victim has private or public insurance) When the victim has Health/Dental/Medicaid Insurance coverage, he/she will have to provide information for all crime related dates of service.
<p>Crime Related Counseling Expenses</p> <p>SOVA provides reimbursement for trauma (generally considered as a medical expense) only when such service is rendered by a professional who is licensed in a specialty which includes mental health counseling; this includes LMSW (when not practicing independently) LPC, LMFT, LCSW, LISW, and MD.</p> <p>For payments to the provider or reimbursements to victims: one or more of the following will be required for all separate crime related dates of service.</p> <p><i>NOTE: SOVA pays after health insurance.</i></p>	<ul style="list-style-type: none"> • SOVA Mental Health Counselor's Report • Itemized Statement of Charges w/CPT codes, or • Health Insurance Claim Form (CMS/HCFA-1500), (Providers can fax a copy to SOVA) • EOB (Explanation of Benefit from Health/Dental insurance company)(Health/Dental/Medicaid must be filed first if a victim has private or public insurance): When the victim has Health/Dental/Medicaid Insurance coverage, he/she will have to provide information for all crime related dates of service.
<p>Crime Related Expenses for Medication</p> <p>For reimbursements to victims: one or more of the following will be required: (Some victims will have to provide additional information from his/her treating physician if the medication is for a pre-existing condition.)</p> <p><i>NOTE: SOVA pays after health insurance.</i></p>	<ul style="list-style-type: none"> • Copy of receipt from the pharmacy (*receipt must have* - patient's name, date, total charge, name of medication, RX number, name of the pharmacy & name of the doctor) or • Print out of 'patient history' from the pharmacy
<p>Crime Related Funeral Expenses</p> <p>The person who is responsible for the funeral expenses incurred may file for reimbursement relating to the cost of the funeral. That will be the person(s) who signed the contract or who paid the funeral bill.</p> <p>If the deceased victim was an adult, the victim's spouse may file for any compensable medical expenses that he/she may have incurred.</p> <p>If the deceased victim was a minor child, the parent may file for any compensable medical expenses he/she may have incurred.</p>	<ul style="list-style-type: none"> • Death Certificate • Itemized bill/contract (* bill must include service provider's name and remit address)



PAYMENTS & REIMBURSEMENTS AT A GLANCE & SUPPLEMENTAL FORMS (continued)

<p>IF: You are requesting assistance with</p> <p>Crime Related Lost Wages</p> <p>The following 4 (four) criteria must be met:</p> <ol style="list-style-type: none"> 1. Employment: The victim must have been employed at the time of the crime, 2. Missed time from work: The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime, 3. Reportable income: Reimbursement is based on reportable income, and 4. Disabled: The victim must be under the care of a treating physician. 	<p>THEN: You will need to provide</p> <p>The following documents must be submitted</p> <ul style="list-style-type: none"> • SOVA Employer’s Report • SOVA Physician’s Disability Report • Copy of your last two pay stubs (prior to the crime date). <p>NOTE: Wages will be offset by other sources such as annual or sick leave, long/short term disability, SSA/SSI.</p>
<p>Crime Related Lost Wages</p> <p>(You were self employed at the time of the crime)</p> <ol style="list-style-type: none"> 1. Employment: The victim must have been employed at the time of the crime, 2. Missed time from work: The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime, 3. Reportable income: Reimbursement is based on reportable income, and 4. Disabled: The victim must be under the care of a treating physician. <p>NOTE: Wages will be offset by other sources such as annual or sick leave, long/short term disability, SSA/SSI.</p>	<ol style="list-style-type: none"> 1) Disability: <ul style="list-style-type: none"> • SOVA Physician’s Disability Report (will be required to establish disability and length of disability) 2) Employment: <ul style="list-style-type: none"> • One or more of the following will be required: (to establish employment) • SOVA Employer’s Report, and/or • 1099, (prior year form will be used for short term reimbursements) (lost wages are calculated using information for the year of the crime) and/or • W-2 (prior year form will be used for short term reimbursements) (lost wages are calculated using information for the year of the crime). 3) Reportable Income: (lost wages are calculated using information for the year of the crime) <ul style="list-style-type: none"> • One or more of the following will be required: (to establish income/reimbursement) • 1040 US Individual Income Tax Return (prior year form will be used for short term reimbursements), • Schedule SE (Form 1040) Self – Employment Tax Form, • Form 4070 – Employee’s Report of Tips to Employer.
<p>Important Information</p>	<p>Unprocessable Forms</p>
<p>The following are forms/documents that are UNPROCESSABLE and can not be accepted</p>	<ul style="list-style-type: none"> • Final Notice • Statements • Bills that are not itemized • Incomplete bills (missing information) • Cash register receipt from pharmacy • Incomplete receipt from pharmacy • Collection notices
<p>Important Information</p>	<p>Non-covered Expenses</p>
<p>The following is a list of some non-covered expenses</p>	<ul style="list-style-type: none"> • Treatment not directly related to the crime on which the claim is based • Over-the-counter items not prescribed by a treating physician • Mileage for court appearances • Hotel accommodations • Public transportation • Food items • Household items • Household utilities

State Office of Victim Assistance ♦ 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 ♦ Phone: (803) 734-1900 ♦ Fax: (803) 734-2261

Refer to instructions and stipulations on reverse side.

Today's Date ____/____/____

Victim's Legal Name _____ Claimant (if a different person) _____

Social Security No. ____/____/____

Crime Date ____/____/____

Is the trauma and the treatment a direct result of this crime? YES ____ NO ____

Presenting Complaint _____

Diagnosis of Record _____

Description of injury and/or psychological trauma as related to victimization _____

HEALTH INSURANCE CARRIER

Policy # _____

() _____

Company Name _____

Telephone No. _____

Mailing Address or P.O. Box _____

City/State/Zip Code _____

Authorized Signature of Treating Therapist/Counselor_____
Printed Name of Payee() _____
Telephone No./Extension_____
License Type and No._____
Mailing Address_____
City/State/Zip Code_____
Supervisor's Signature_____
License Type and No._____
Date**NOTE: SOVA does NOT act as guarantor for any services rendered.**

Mental Health Counseling Reimbursement

DEFINITION

Mental health counseling for compensation purposes means “the assessment, diagnosis and treatment of an individual’s mental and emotional functioning that is required to alleviate psychological trauma resulting from a compensable crime.” This definition is in accordance with state statutes that afford reimbursement for medical expenses on behalf of eligible victims.

SUPPORTING DOCUMENTS REQUIRED

- ❖ **Mental Health Counselor’s Report** form must be completed by the victim’s counselor and must certify whether the psychological trauma being addressed is a direct result of the crime
- ❖ **Itemized bill in the victim’s name** from the mental health counselor detailing the actual dates of service, type of service provided (i.e. individual, group, medication management), the CPT code assigned, and the amount charged

LICENSED PROFESSIONAL

SECTION 16-3-1180(A)(1) An award may be made for: reasonable and customary charges as periodically determined by the board for medical services, including mental health counseling, required and rendered as a direct result of the injury on which the claim is based, as long as these services are rendered by a licensed professional. Payment for mental health counseling is limited to the number of sessions during a one hundred eighty-day-period beginning on the date of the first counseling session or twenty sessions, whichever is greater. Upon recommendation of the director, the board may allow victims who max out the current benefit of twenty mental health counseling sessions to request up to an additional twenty sessions for a total of forty sessions;

Pursuant to 16-3-1180(A)(1) Effective January 2009: Upon recommendation of the director, the board may allow victims who max out the current benefit of twenty mental health counseling sessions to request up to an additional twenty sessions for a total of forty sessions. If a victim reached the maximum counseling benefits prior to January 2009, this does not apply.

LIMITATIONS: Reimbursement amount is based on a fixed fee scale:

Individual Counseling:

- LMSW, LPCI - \$75.00/hr.
- Supervised Interns - \$75.00
- LPC, LCSW, LMFT & LISW - \$90.00/hr.
- MD - \$105.00/hr. (Include: medication management)
- MD \$53.00/hr. (Include: medication management)

Group Counseling:

- LMSW, LPCI - \$37.50/hr.
- Supervised interns -\$37.50/hr.
- LPC, LCSW, LMFT & LISW - \$45.00/hr.

- ❖ Financial assistance is limited to any number of sessions within 180 days of the first charged visit (up to the allowable recovery amount including other benefits) or 20 sessions scheduled as needed for resurfacing trauma, whichever is greater.
- ❖ Effective January 2009 - The victim may be eligible for additional sessions upon showing a need.
- ❖ SOVA pays the outstanding balance from bills not fully covered by existing medical insurance. If a victim has private or public medical insurance to include Medicaid/Medicare, bills must first be filed with applicable companies/carriers before submission to the agency for possible payment.

NOTE: Family sessions are reimbursed using the individual counseling fee scale.

NOTE: SOVA does not reimburse LMSW’s practicing privately or independently for clinical services, including mental health counseling.

NOTE: Counseling sessions for offenders are not compensable under the Victim Compensation Program.

SOVA Physician's Disability Report - Lost Wages Rev. 1/10

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An application for assistance has been filed with our office for the crime victim listed below.
Please complete this form and return it to us as soon as possible; a fax is acceptable.

Full name of injured patient _____

Social Security No. ____ / ____ / _____

Date of Birth ____ / ____ / _____

Date the patient was first seen by you ____ / ____ / _____

Date of crime related injury ____ / ____ / _____ (must be completed)

Diagnosis: _____

Briefly describe extent and location of injuries: _____

Did the patient sustain any disability? Yes No (Please circle one.)

If yes, is the disability solely a result of this injury? Yes No (Please circle one.)

Please explain: _____

Patient will be totally unable to work from ____ / ____ / ____ through ____ / ____ / ____

Has the patient been discharged from your care? Yes No (Please circle one.)

Has payment been filed with any of the following?

Medicaid Yes No Policy # _____

Medicare Yes No Policy # _____

Workers' Compensation Yes No

Other insurance or program Yes No Company or Agency _____

Address _____

Type or print physician's name _____ Phone (____) _____

Signature of physician _____ Date ____ / ____ / ____

Address of physician _____

**Form must be faxed or mailed by provider.

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SOVA Claimant/Applicant filing for benefits (*print full name*) _____

Job Type _____ Social Security No. ____ / ____ / _____ Date of Birth ____ / ____ / _____

Employer: An application for assistance has been filed for the person listed above.***Please complete this form and return it to SOVA as soon as possible; a fax is acceptable.****Date the above person was first employed by you* ____ / ____ / _____*Date he/she was first absent due to crime related injuries* ____ / ____ / _____*Date he/she returned to work part time, if applicable* ____ / ____ / _____*Date he/she returned to work full time* ____ / ____ / _____*Date he/she was terminated, if no longer employed by you* ____ / ____ / _____**Insurance Type and Policy No.**

Health/Medical # _____ Disability # _____

Lost wages will be offset by other sources such as annual or sick leave, long/short term disability, SSA/SSI.*Was this employee compensated for time absent from work?* _____ *If so, how much?* _____*Daily Work Schedule: from* ____ *am/pm to* ____ *am/pm**Average work hours per week* _____ *Average overtime per week* _____*Average hourly wage* _____ *Overtime hourly wage* _____*Gross salary per week* _____ *Average commissions per week* _____

Employer _____ Address _____ Phone No. (____) _____

Person Completing Form (*print*) _____ *Signature* _____*Title* _____ *Date* _____ *Comments?* _____****Further documentation may be required to receive lost wages/support, i.e., W-2, pay stubs, or tax returns. Wages will be offset by other sources such as annual or sick leave, social security or disability.******Form must be faxed or mailed by employer.**