Office of
Victim Services

KATHY HOCHUL
Governor

ELIZABETH CRONIN, ESQ
Director

MENTAL HEALTH TREATMENT REPORT – OUTPATIENT

Date of Report: _____

Claim Number: _____ Date of Crime: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Telephone: ( ) _____ Email: _____

Date Treatment Began: _____ Continuing? Yes ____ No ____

Termination Date (if applicable): _____

PLEASE RESPOND TO ALL ITEMS – USE ADDITIONAL PAGES IF NECESSARY

1. Please provide a brief description of the crime as it was relayed to you:

2. Is the trauma a direct result of crime that occurred on the date listed above? Yes_____ No _____

   If Yes, please describe, in detail, the relationship between the crime and the need for treatment.

3. In your opinion, what percentage of treatment is a direct result of the crime? **This must be completed.**

   ☐ 100% ☐ 75% ☐ 50% ☐ Other:

4. Does the victim have any history of previous mental health treatment? Yes _____ No _____
   If Yes, please indicate the approximate dates of treatment and the reason for treatment:

5. In your opinion, would the claimant/victim be in treatment if it weren't for the crime?

6. DSM-V Diagnoses (indicate bot the diagnosis and the corresponding ICD-10 codes).

Principal Diagnosis:

Additional Diagnosis:

7. Treatment Goals and Prognosis

A. Specify the type of treatment being done:
B. Please list the frequency and length of sessions:
C. Describe the prognosis:

Anticipated termination date (**must enter date**):

_____

Payor of Last Resort Status:	
By law, the New York State Office of Victim Services is the payor of last resort. Please be advised. OVS pays what is listed on the insurance explanation as the patient's responsibility. An insurance explanation of benefits, or denial, is required if the patient has any insurance coverage. OVS cannot issue any payments without this documentation. It is the provider's (or patient's) responsibility to make sure any insurance coverage is considered.	
The following question must be answered:	Does the victim have any health insurance coverage? Yes_____ No_____
If Yes, Health Insurance Carrier:_____ Policy Number:_____	

_____ _____

Signature of Provider Date

PROVIDER INFORMATION

NAME: _____ CREDENTIALS: _____

ADDRESS: _____

AGENCY _____

TELEPHONE # ( ) _____ SOCIAL SECURITY/TAX ID #: _____

EMAIL: _____ LICENSE # _____