



Violence Peer Counselor Billing Form

CaVCP Application No.: A- _____

Please fax this form to California Victim's Compensation Program at (916) 491-6423. For claim status information, you may call the Board's toll free number 1-800-777-9229.

Instructions: Please type or print						
Claimant Information						
Claimant Name (First, Last)					Phone Number	
Mailing Address			City		State	Zip
Organization & Violence Peer Counselor Information						
Name of Service Organization					Name of Violence Peer Counselor	
Organization Address					Organization Phone Number	
Name of Supervising Therapist					Supervising Therapist Job Title	
License Number					Expiration Date	
Billing Information						
SERVICE ORGANIZATION TAX IDENTIFICATION NO.: EIN [_____]						
DATES OF SERVICE	DESCRIPTION OF SERVICE				SESSION LENGTH (minutes)	BILLED AMOUNT
	INDIVIDUAL	GROUP	FAMILY	SPECIFY OTHER		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____		\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____		\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____		\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____		\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____		\$
					TOTAL CHARGES	
					FOR THIS BILL: \$	
<p><u>SUPERVISING THERAPIST DECLARATION:</u> I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have reviewed all applicable case notes pertaining to the application information contained on this form and to the best of my information and belief, all my answers are true, correct, and complete, and; (2) all treatment noted on this bill (including attachments) was necessary as a direct result of the crime described on the patient's original application for compensation. I further understand that if I have provided any information that is false, intentionally incomplete, or misleading, I may be found liable under Government Code section 12651 for filing a false claim with the State of California and may be found accountable to the state for the costs of a civil action brought to recover any of those penalties or damages of not less than \$5,500 and not more than \$11,000 for each violation.</p>						
Peer Counselor Signature			Date	Supervising Therapist Signature		Date



INSTRUCTIONS FOR COMPLETING THE VIOLENCE PEER COUNSELOR BILLING/VERIFICATION (B/V) FORM

This form must be fully completed for payment to be considered. Incomplete forms will delay payment. Services billed on this form may be reimbursed when:

- The claim has been found eligible by California Victim's Compensation Program (Program);
- Services are provided by a peer counselor who meets the training and experience requirements;
- Supervising therapist attests to the counseling services provided by the peer counselor.

When completing this form, please be advised:

- A maximum of ten (10) sessions are allowed, \$15/hour.
- A separate B/V Form must be submitted for each qualifying direct or derivative victim receiving individual violence peer counseling.

CLAIMANT INFORMATION – Provide all information relating to the claimant.

SERVICE ORGANIZATION – Indicate the name of the organization that employs the violence peer counselor.

NAME OF VIOLENCE PEER COUNSELOR – Provide the name of the individual peer counselor providing services for the direct or derivative victim(s).

SUPERVISING THERAPIST INFORMATION – Include all pertinent information including the supervising therapist's name, title, license number, license type and telephone number.

PAYEE TAX IDENTIFICATION NUMBER – Provide the tax identification number for the service organization.

BILLING INFORMATION:

- **DATE OF SERVICE** – Indicate the date of service counseling was provided.
- **DESCRIPTION OF SERVICE** – Indicate the type of counseling provided (individual, group, family, etc.)
- **SESSION LENGTH** – Indicate if session was one session, half session, etc.
 - *Individual / Family Sessions: ½ session =up to 44 minutes; 1 session= 45-74 minutes; 1 ½ sessions =75-104 minutes*
 - *Group Sessions: ½ session =60 minutes; 1 session =120 minutes; 2 sessions =240 minutes*
- **BILLED AMOUNT** – Indicate the amount that is being billed.
- **TOTAL CHARGES** – Tally the total amount owed for the services indicated. DO NOT include balance forward information.

SUPERVISING THERAPIST DECLARATION – The supervising therapist and violence peer counselor must read the declaration and sign and date the billing verification form.

TO OBTAIN ADDITIONAL FORMS OR ASK QUESTIONS - You may call the Program toll-free at 1-800-777-9229. You may also visit our website at <http://www.vcgcb.ca.gov> for program information and various forms.

Privacy Notice on Collection

1. VCGCB collects this information based on California Government Code sections 13952 et seq. and 13954.
2. All information collected from this site is subject to, but not limited to, the Information Practices Act. See <http://vcgcb.ca.gov/media/pract.aspx>.
3. This information is collected for the purpose of determining eligibility for compensation.
4. VCGCB may disclose your personal information to another requestor, only if required to do so by law or in good faith that such action is necessary to:
 - a. Conform to the edicts of the law or comply with legal process served on VCGCB or the site;
 - b. Protect and defend the rights or property of VCGCB; and,
 - c. Act under exigent circumstances to protect the personal safety of users of VCGCB, or the public.
5. Individuals are to provide only the information requested.
6. The information provided is mandatory.
7. The consequences of not providing the requested information could result in the denial of your application.
8. You have the right to access the records containing the personal information that you provided.
9. The information collected is used by the California Victim Compensation Program.
10. Any questions regarding the information collected, please write to the following address: 400 R Street, 5th Floor Sacramento, CA 95811, email info@vcgcb.ca.gov, call (800) 777-9229, or contact the VCGCB Privacy Coordinator at InfoSecurityandPrivacy@vcgcb.ca.gov.
11. For additional information regarding privacy, please see VCGCB's Privacy Notice. See <http://vcgcb.ca.gov/privacy.aspx>.
12. For information regarding consumer information on security, please visit <https://oag.ca.gov/privacy/online-privacy>.