C A L I F O R N I A
VCGCB
Victim Compensation & Government Claims Board

Additional Treatment Plan (Form)
(Confidential)

State ofCalifornia **Additional Treatment Plan** VCGCB-VOC-6025 *(Revised 4-1-11)*	**CaliforniaVictim Compensation and Government Claims Board (CalVCP) (www.vcgcb.ca.gov)**

Return Form To: **CalVCP** **P.O. Box 942003** **Sacramento, CA 94204-2003**	**Application Number:**	**Date Form Sent:**
	Claimant Name:	
	Date That Crime Occurred:	

Please submit this form if your client is within **eight (8)** sessions, or has reached the mental health benefit limitations noted below and additional treatment is necessary as a direct result of the crime for which the California Victim Compensation Program (CalVCP) application was filed. If you are the continuing therapist, please include a copy of your initial **Treatment Plan**, (to be completed before client's sixth (6) session.) **The CalVCP is unable to authorize and reimburse additional sessions until the Additional Treatment Plan is reviewed and approved.** Further information, such as **session notes** or objective assessments of impairment, may be needed to evaluate this request for additional treatment. You will be notified by mail of the result of the review.

As required by law, the information requested must be returned to the CalVCP within ten (10) business days from the date of the cover letter and must be provided at no cost to the claimant, the CalVCP, or local Victim/Witness Assistance Centers. The CalVCP certifies that there is a signed authorization on file for the release of the information requested. Pl ease answer questions fully and complete the signature page at the end of the document. You may use additional pages if necessary.

Note: Additional sessions awarded to an **adult derivative victim**, except for when the direct victim is deceased due to the crime, must be for the **benefit of the direct victim**.

Mental Health Session Limitations

Session Limitation	Claimant/Patient Filing Status
40 Session Hours	Direct Victim
30 Session Hours	* Direct Victim of Unlawful Sexual Intercourse (Penal Code, section 261.5(d)) Derivative Victim who is a surviving parent, sibling, child, spouse, registered domestic partner, or **fiancé (fiancée) of a victim who becomes deceased due to the crime * Derivative Victim who was a minor at the time of the crime Derivative Victim who was one of two primary caretakers of a direct victim who was a minor at the time of the crime ** Minor witness to violent crimes (Statutory limit of $ 5,000.00)
15 Session Hours	* Derivative Adult Victim * A Derivative Victim who does not meet any of the benefit limits listed above Post-Crime Caretakers (became primary caregiver of minor direct victim after the qualifying crime and did not have a previous relationship to the direct victim) Statutory limit of $5,000.00.

* Not to exceed the statutory $3,000 outpatient mental health limit for applications received prior to 01-01-08
** Must have witnessed the crime

Session Calculations (Individual/Family Therapy)

½ Session =	Less than 45 minutes
1 Session =	45 - 74 minutes
1½ Session =	75 - 104 minutes
2 Session =	105 - 120 minutes

Session Calculations (Group Therapy)

½ Session =	60 minutes
1 Session =	120 minutes
1½ Session =	180 minutes
2 Session =	240 minutes

Please complete all questions unless otherwise specified.

1. Claimant's Relationship to Victim: ☐ Self   Other (please specify)

2. Name of Treating Therapist:

   Provider/Organization (if applicable):

3. What is your present understanding of the details of the crime for which you are providing treatment?

4. If this victimization was not within the last year, or if there has been a break in treatment of one year or longer, please describe the event(s) that brought the claimant into treatment at this time and describe how the event(s) are related to the qualifying crime.

5. Please evaluate this claimant with respect to the criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Please complete this section as fully and accurately as possible, and evaluate on all 5 axes.

   Axis I: ______ Axis II: ______

   Axis III: ______ Axis IV: ______

   Axis V (GAF): ______ SOFA: ______ ☐ N/A-Client is under 6 years of age GARF: ______

6. If you are the continuing therapist, and the current impairment scores are lower than the scores on your previous Treatment Plan(s), please explain.   ☐ N/A - New Therapist (under 15 sessions provided)

7. Please describe any factor(s) not already noted which you believe may have a significant impact on the course of your treatment of this claimant:

8a. If you are the **continuing therapist**, please rate the status of the claimant's symptoms/behaviors, as shown on your Treatment Plan, on a scale from 1 to 9, with 1 representing the lowest score and 9 the highest.

Worsened			Remained Relatively the Same			Improved		
1	2	3	4	5	6	7	8	9

Symptom/Behavior: Rating :

Symptom/Behavior: Rating :

Symptom/Behavior: Rating :

8b. If you are a new therapist, (or continuing therapist treating additional symptoms/behaviors) what symptoms/behaviors will be or have been the focus of your treatment?

Symptom/Behavior: Intervention:

Symptom/Behavior: Intervention:

Symptom/Behavior: Intervention:

8c. If your client is a derivative victim, what symptoms/behaviors of the direct victim will be the focus of this claimant's treatment, and what interventions with the derivative victim will be aimed at the recovery of the direct victim?

Symptom/Behavior: Intervention:

Symptom/Behavior: Intervention:

Symptom/Behavior: Intervention:

Is the direct victim currently in treatment? ☐ Yes ☐ No ☐ Unknown

9. Will family/conjoint sessions be used during treatment? ☐ Yes ☐ No

10. How will progress be measured? Please specify the tests you expect to use:

11a. Date your treatment began: Most recent date of treatment:

Number of sessions completed: Individual: ____________ Family: ____________

Group: ____________ Conjoint: ____________

Has treatment terminated (Claimant will not be returning for future sessions)? ☐ Yes ☐ No

Date of termination:

11b. If you are seeking compensation for previously billed dates of service only, please list the dates of service for which you are seeking reimbursement.

12. Did, or will, this claimant testify in any criminal or dependency proceeding related to the qualifying crime?

☐ Yes - If "yes," please provide the date of the court proceeding: ____________ (Month)/ (Year)

☐ No

13. Was the perpetrator of the crime released from custody?

☐ Yes - If "yes," please provide the date the perpetrator was released from custody: ____________ (Month)/ (Year)

☐ No

☐ N/A

14. If you are a continuing therapist, please indicate the overall percentage of treatment completed in relation to the qualifying crime.

____________% ☐ N/A New Therapist

15. If this claimant is a minor, is there a primary caretaker(s) involved in the treatment? ☐ Yes ☐ No ☐ Not a minor

If yes, please explain the nature and extent of involvement:

16. Has this treatment plan been discussed with and consented to by the claimant or the claimant's caretaker?

☐ Yes ☐ No

DECLARATION

CLAIMANT NAME: APPLICATION NUMBER:

If the victim's offender is convicted, the CalVCP will request the criminal court to order the offender to pay restitution to reimburse the CalVCP for any expenses the CalVCP has paid for this crime. As a treating therapist you must be prepared to testify in a restitution hearing that the mental health counseling services you provided were necessary as a direct result of the crime at the percentage indicated below.

Please Note: ***The CalVCP can only pay for the percentage of treatment that is necessary as a direct result of the crime for which the application was filed.***

A. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

☐ 50% ☐ 100% ☐ Other: ________%

☐ 75%

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 read all of the questions 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 submitted for reimbursement by the CalVCP or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above. 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 12650 for filing a false claim with the State of California and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

I understand that mental health counseling must be approved in advance, and that if treatment is provided without the required approval, the CalVCP may not reimburse those expenses.

IMPORTANT - You MUST Provide The Required Signature(s) and Date(s) Below.

Treating Therapist:

Name: ______________________ License No.: ______________

Signature: ______________________ Date: ______________

If Treating Therapist is a Registered Intern:

Supervising Therapist's Name: ______________________ License No.: ______________

Signature: ______________________ Date: ______________

Tax Identification Number of person or organization in whose name payment is to be made:

E-mail Address: ______________________

Telephone Number: ______________________