Mental Health Treatment Plan

Crime Victim Compensation
Seventeenth Judicial District
1000 Judicial Center Drive Suite 100
Brighton, CO 80601
Victimcomp.com
Fax: 303-835-5575

Victim Claim #: _____

Approval of initial therapy or submission of this form does not guarantee payment of continued treatment. Any and ALL treatment costs exceeding the approved amount determined by the Board are the responsibility of the claimant. The client will be notified by mail of all Board decisions. Due to the number of treatment plans reviewed by the Board each month, you are required to enter this form into a word processing program.

- Handwritten forms will be returned without being reviewed.
- The client or parent/guardian must sign the form before payment can be made.

THERAPIST INFORMATION SECTION:

Name:
Address:
City/State/Zip:
Telephone Number:
Fax Number:

Supervisor:
Address:
City/State/Zip:
Telephone Number:

CLIENT INFORMATION SECTION:

Name:
Address:
Date of Birth:
Claim Number:

Parent/Guardian:

FAMILY INFORMATION SECTION:

List family members that will be involved in treatment related to the victimization and respective therapist name (sessions involving the defendant/perpetrator will not be covered):

PERPETRATOR INFORMATION SECTION:

Name:
Relationship to victim:
What contact does the perpetrator currently have with the victim/client?

TREATMENT PLANNING SECTION:

1. Briefly describe victimization.

2. What behavior and emotional symptoms directly related to the victimization is the victim/client currently displaying?

3. Describe the victim's mental health prior to the crime and indicate the source of your information (client report, previous clinical report, observations).

4. How will pre-existing issues be addressed?

5. List the treatment goals and objectives relative to the victimization. Each goal should have a target completion date included.

6. Discuss treatment modalities used to achieve these goals.

7. Describe any issues that may increase or decrease the length of treatment or effectiveness of services provided.

ESTIMATED LENGTH OF TREATMENT SECTION:

Date client entered treatment:_____Number of sessions to date: _____

Number of sessions you would like to Board to consider:

$80 per individual session at _____ (number of) sessions: Total $_____
$40 per family session at _____ (number of) sessions: Total $_____
$40 per group session and _____ (number of) sessions: Total $_____
Total Amount Requested: $_____
Anticipated Termination Date:_____

INSURANCE INFORMATION SECTION:

I am a provider for my clients insurance? Yes/No

Company: Telephone Number:
Type of Mental Health Coverage:
Number of Sessions Allowed:
Policy Number:

*Please include a copy of the Explanation of Benefits (EOB) with invoices that have been billed to insurance. If insurance is available but is not going to cover services, a letter of denial or phone call to the Compensation Program must be provided.

SIGNATURE OF CLAIMANT SECTION:

Is the victim/client aware of and in agreement of this treatment plan and estimated number of sessions and cost?

_____ _____
Victim/Client or Parent/Guardian Signature (required for payment) Date

SIGNATURE OF THERAPIST SECTION:

I have read and understand the Mental Health Guidelines as provided to me by the Seventeenth Judicial District Crime Victim Compensation Program. I agree to bill for only the sessions and services which are allowable pursuant to the Bylaws and Policies of the Seventeenth Judicial District and outlined in the Mental Health Guidelines. I understand that Crime Victim Compensation is, by statute (C.R.S. §24-4.1-110), the payer of last resort, and I agree to submit bills to insurance when applicable. I further agree to only bill Crime Victim Compensation for sessions that are related to the victimization of the criminal incident for which my client has applied and which are part of the above submitted treatment plan.

Therapist Signature	Supervising Therapist