20TH JUDICIAL DISTRICT CRIME VICTIM COMPENSATION
Office of the District Attorney, 1035 Kimbark St., Longmont, CO 80501
Phone: 303-682-6801 Fax: 303-682-6711
www.bouldercounty.org/da

INITIAL ASSESSMENT AND MENTAL HEALTH TREATMENT PLAN

MENTAL HEALTH SERVICE PROVIDER:
(*This form must be typewritten or legibly printed. Please attach additional information to this form if necessary.*)

This client has applied for funds under the Crime Victim Compensation Act. The 20th Judicial District Crime Victim Compensation Board requires pre-authorization of funds for your client's mental health costs. If your client (or parent/guardian) has applied to our program for assistance with mental health counseling and their claim has been approved they should be able to present you with a letter from the 20th Judicial District Crime Victim Compensation Program, authorizing six (6) mental health sessions to allow you develop an initial assessment and treatment plan. Please keep a copy of both the award letter and this form for your records. A separate treatment plan is required for each family member applying for assistance.

The completion of this form does not constitute approval of this claim past the six (6) sessions that were approved by the Board to develop a treatment plan. If additional sessions are authorized you will be notified by mail of the amount that the Board has set aside for future sessions. Any unused portion of the authorization will revert back to the fund one year after approval of the authorization.

If an application is approved, the Crime Victim Compensation Board reserves the right to request a progress report at their discretion.

Note: This treatment plan may be subject to discovery in court proceedings.

Client Name: ____ Phone: _________________
Address: ____
Client's DOB: ______ If client is a child, please provide the name of the parent/guardian who has applied to our program on the child's behalf: __________________________________
Circle One: Primary Victim Secondary Victim
Therapist Name: ______________________________________ Phone: _________________
Address: ____
Your state license number: ____________________________ (Please attach a copy of license)
Circle One: M.D. Ph.D. M.A. M.S. M.S.W. OTHER: ___________
The 20th Judicial District Crime Victim Compensation Program will only approve funding to state licensed therapists. Consideration will be made on a case-by-case basis if there are special circumstances. In this instance, a state licensed therapist MUST supervise the therapist. Therefore, if you are unlicensed and supervised by a licensed therapist please provide us with the following:

Name of your supervising therapist: ___________________________ License #_____________

EXPERIENCE:
(If you have worked with our program before and have provided your resume to us, please check here: _____. You do not need to fill out this section regarding experience.)

1. Our program requires that you demonstrate experience and education related to crime victim issues. ***Please use the space below to detail the training you have received in this area and also submit a copy of your resume and current license with this form.***

2. If this client is a child or adolescent, please include information on your education and experience working with this age group.

____

Perpetrator Information:

Perpetrator's Name: ____
Perpetrator Relationship to the Victim: ____
Perpetrator's Therapist (if known): ____
Perpetrator's Current Living Situation (if known): ____________________________________

Family Information:

Are other family members in treatment? ____

If known, what has been the reaction of the victim's family in regard to the victim, perpetrator and the crime in general?

TREATMENT:

1. What behavioral and emotional symptoms directly relating to the victimization is your client is currently displaying?

2. Clinical diagnosis:

3. Victim Compensation funds are primarily for the treatment of trauma that occurred as a result of the criminal incident which prompted your client to apply to our program. Describe any pre-existing mental health condition that you may be treating. Please include information on any medication your client may be taking for a pre-existing mental health condition.

4. Is this client reporting any substance abuse issue? Yes ____ No ____
   If yes, what is your plan for treatment?

5. What are the treatment goals and objectives (please state if treatment is specifically related to crime or unrelated):
   1.

   2.

   3.

6. Discuss treatment modalities that will be used to achieve these goals:

7. What treatment referrals are being made at this time ***for primary victim only*** (psychological assessment, group therapy, medication evaluation, self-defense or massage therapy)? *Please note: Any future referrals will require a letter of explanation.*

COST OF TREATMENT AND PROJECTED LENGTH OF TREATMENT

Crime Victim Compensation is, by statute, the Payer of Last Resort, and as such, all health insurance coverage including Medicaid and Medicare must be utilized prior to the Crime Victim Compensation program making an award.

We will pay a maximum of $75.00 per individual session and/or $35.00 per group session. We encourage therapists to accept our maximum per session to lessen the financial impact to our clients. If you charge more than our maximum session rate, it is your responsibility to inform you client of their share of the cost.

Our program will NOT pay for the following: Court ordered therapy, missed or cancelled appointments, trial attendance by the therapist, report writing, marital counseling and sessions that are not focused on issues directly related to the criminal incident for which the client is applying. This is necessary to preserve the limited funds that are available and to maintain equitable compensation among those we serve.

Your client must provide you with information on how to bill his/her insurance company, if coverage is available. You may then bill Victim Compensation for the amount not covered by your client's insurance (patient's portion.) Please have your client provide us with insurance information in the appropriate section below.

1. Total number of sessions needed for treatment: ______________
2. Frequency of therapeutic contacts: _______________
3. Date of first session: __________ (if this is a client you have been treating prior to the crime, please give date of first session dealing primarily with victimization issues.)
4. Anticipated termination date: ________________
5. Does your client have insurance that covers any portion of the treatment? Yes ___ No___
   If yes, please provide the following information:
   Name of insurance company: ________________________ Phone: _______________
   Deductible: _________________ Amount paid by insurance per visit: ___________

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

By completing and signing our treatment plan, you are acknowledging that the sessions being provided are related to the crime.

________________________ ____
Date Therapist's signature

________________________ ____
Date Supervisor's signature (if treating therapist is unlicensed.)

________________________ ____
Date Client's/Guardian's signature

PLEASE RETURN TO:
Office of the District Attorney, 20th, Judicial District
Attn: Crime Victim Compensation, 1035 Kimbark St., Longmont, CO 80501

Revised: 02/10