Treatment Plan/Additional Treatment Plan
Information Sheet

Please read the following information carefully prior to completing the Treatment Plan (TP) or Additional Treatment Plan (ATP). Failure to entirely complete the forms timely and legibly may result in denial of reimbursement or a repayment to the California Victim Compensation Program (CalVCP) for services previously reimbursed.

General Information:

In order for CalVCP to pay for services, the claimant's application must be found eligible. After eligibility has been determined, CalVCP may consider reimbursement for outpatient mental health counseling up to the claimant's session limit, as shown in Table A.

Statute requires that CalVCP verify that treatment is necessary as a direct result of the crime for which the application was filed. To verify appropriateness of reimbursement, additional information (i.e. session notes or a letter of explanation) may be requested.

Additionally, the requested additional information must be provided at no cost to the claimant, CalVCP, or local Victim/Witness Assistance Centers within ten (10) business days from the date of the request. Failure to complete the Treatment Plan and/or provide the requested additional information may result in denial of reimbursement or a repayment to CalVCP for services previously reimbursed. CalVCP certifies that there is a signed authorization on file for release of the information requested.

TABLE A
Mental Health Session Limitations
(For applications received on or after 01-24-06)

Session Limitation	Claimant/Patient Filing Status
40 Session Hours	Direct Victim – $10,000 statutory limit 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 – $10,000 statutory limit[2,3]
30 Session Hours	Direct Victim of Unlawful Sexual Intercourse (as defined by Penal Code, section 261.5(d)) – $5,000 statutory limit[1] Derivative Victim who was a minor at the time of the crime – $5,000 statutory limit[1] Derivative Victim who was one of two primary caretakers of a direct victim who was a minor at the time of the crime – $10,000 statutory limit (to be shared with one other primary caretaker) Minor witness to violent crime (eff. 01-01-09) - $5,000 statutory limit[2] Good Samaritan (as defined by Government Code, section 13970) - $10,000 statutory limit[3]
15 Session Hours	Derivative Adult Victim – $5,000 statutory limit[1] Derivative Victim who does not meet any of the benefit limits listed above – $5,000 statutory limit[1] Post-Crime Caretakers (became primary caregiver of minor direct victim after the qualifying crime and did not have a previous filing status relationship to the direct victim) - $5,000 statutory limit

1) Not to exceed the statutory $3,000 outpatient mental health limit for applications received prior to 01-01-08
2) Must have witnessed the crime
3) Effective for applications received on or after 12-01-14

TABLE B

Session Counts (Individual/Family Therapy)

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

Session Counts (Group Therapy)

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

Submittal of the Completed Treatment Plan

The Treatment Plan may be kept in the claimant's file, but must be submitted to CalVCP in the following circumstances:

• There has been a three year delay in treatment from the date or disclosure of the qualifying crime.
• There has been a break in mental health treatment of one year or longer.
• Treatment beyond the claimant's third session is less than 100 percent related to the qualifying crime.
• Upon submission of an Additional Treatment Plan.
• A Restitution Hearing against the offender has been ordered.
• The claimant is a post-crime caretaker.
• Upon request of CalVCP.

Submittal of the Completed Additional Treatment Plan

Should the claimant require treatment in excess of his or her authorized session limit, an Additional Treatment Plan (ATP) must be submitted with the TP and approved by CalVCP. The ATP should not be completed before the claimant is within eight (8) sessions from reaching his or her authorized session limit.

The ATP must be submitted within 90 days after the date a bill for sessions that exceed the authorized session limit is received by CalVCP. If the ATP and TP are not submitted within the 90 day timeframe, bills for all dates of service that exceed the authorized session limit will be returned and will not be considered for payment. However, bills for dates of service provided after the ATP and TP are received may be considered for payment, subject to approval of the ATP (California Code of Regulations, section 649.26(c).

Please be advised that sessions provided to the claimant by another mental health provider are counted against the amount of sessions available under his or her initial session limit.

You may contact customer service for session count/limit verification (800-777-9229).

Treatment Plan
(Confidential)

As a condition for reimbursement, this treatment plan must be completed in its entirety before the completion of the fourth session. Failure to entirety complete this form legibly may result in denial of further reimbursement or a repayment to the California Victim Compensation Program (CalVCP) for services previously reimbursed. **CalVCP recommends that therapists review the Treatment Plan/Additional Treatment Plan Information Sheet prior to completing this form.**

Return this form to: CalVCP
P.O. Box 942003
Sacramento, CA 94204-2003

Application Number:	Date the Qualifying Crime Occurred:		
Claimant/Client Name:	Date Treatment Began:		
Direct Victim Name:	Most Recent Date of Treatment:		
Agency/Organization (if applicable):	Number of Sessions Provided:		
	Individual	Group	Family/Conjoint
Treating Therapist Name and Licensure:			
Email Address (required for notification):			
Telephone Number:			

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

2. Please describe the crime(s) for which you are providing treatment including relevant detail provided to you.

3. If the victimization occurred longer than three years ago or there was a break in treatment of one year or longer, describe the events, behaviors or reasons the claimant has sought treatment at this time.

IF CLAIMANT IS A POST-CRIME CARETAKER, SKIP TO QUESTION NUMBER 12 (page 3)

4. Please indicate the DSM 5 code of the claimant's diagnosis and specifiers, and other conditions that may be the focus of clinical attention. If the criteria for a diagnosis are not present, please provide the Z-Code (i.e. V-Code in previous DSM versions).

   Principal Diagnosis: Additional Diagnoses:

5. Please describe the symptoms/behaviors that will be the treatment focus and interventions you will use to treat each symptom/behavior.

Symptom/Behavior	Intervention

6. Level 1 Cross-Cutting Symptom Measure (Please refer to pages 734-741 of the DSM 5.)

Adults			
Domain	Highest Score	Domain	Highest Score
I.		VII.	
II.		VIII.	
III.		IX.	
IV.		X.	
V.		XI.	
VI.		XII.	
		XIII.	

Children			
Domain	Highest Score	Domain	Highest Score
I.		VII.	
II.		VIII.	
III.		IX.	
IV.		X	
V.		XI.	
VI.		XII.	

7. Please identify any standardized tests you will use to measure treatment progress (e.g. PTSD Checklist, Child Behavioral Checklist, Youth Self Report, Beck Depression Scale, WHODAS, etc.)

8. **If the claimant is an adult:** Please describe any factors you believe may adversely affect treatment progress. Consider factors such as inadequate housing, employment, physical health, transportation, child care and social network.

9. **If the claimant is a child:** Please describe any factors you believe may adversely affect treatment progress. Consider such factors as living circumstances, inadequate caretakers, educational or developmental delays and peer support network.

10. Do you expect the claimant to have further contact with the legal system in regard to the qualifying crime?

☐ Yes ☐ No

If answer is yes, please explain:

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

Month Year

☐ Yes – If "yes" please provide the date the perpetrator was released from custody _____/_____

☐ No

☐ N/A

12. Do you expect the claimant will be subject to uninvited or unwelcome contact with the alleged suspect that is not court authorized?

☐ Yes ☐ No

If answer is yes, please explain:

13. **If the claimant is a post-crime caretaker** (i.e., foster parent, relative caretaker), please list and describe the interventions aimed at alleviating the direct victim's symptoms.

Direct Victim's Symptoms/Behaviors	Interventions for the Post-Crime Caretaker

14. Has the claimant terminated treatment (i.e. claimant not returning for treatment at this time)?

☐ Yes ☐ No

Date of termination _____

DECLARATION PAGE

Application Number: _____ **Claimant Name:** _____

If the victim's offender is convicted, CalVCP will request the criminal court to order the offender to pay restitution to reimburse CalVCP for any expenses CalVCP has paid for this crime. As a treating therapist you may be required 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: 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.

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

☐ 50% ☐ 75% ☐ 100% ☐ Other _____%

If it is your professional opinion that subsequent treatment is not 100% related to the qualifying crime, the Treatment Plan must be submitted to CalVCP for review upon completion of the claimant's fourth session.

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 CalVCP or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above.

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

This document will not be reviewed without the required signature(s) and date(s) below.

Treating Therapist:

Name: _____ License No. _____
(Please Print Clearly)

Signature: _____ Date: _____

If Treating Therapist Requires Supervision:

Supervising Therapist's Name: _____ License No. _____
(Please Print Clearly)

Signature: _____ Date: _____