

Crime Victim Compensation

First Judicial District
500 Jefferson County Parkway, Golden, CO 80401
Phone: 303.271.6846 Fax: 303.271.6785
Email: da-cvc@jeffco.us

Mental Health Treatment Plan

Important:

- 1) This form **MUST BE TYPEWRITTEN**
- 2) Award for initial assessment sessions does not guarantee approval of additional sessions.
- 3) Any treatment costs exceeding the approved amount determined by the Board is the responsibility of the client.
- 4) The client and mental health provider will be notified of the Board decision within 10 days after the Board meeting.
- 5) Incomplete and handwritten forms (including required signatures) will be returned without being reviewed.

Therapist Information:

Name:	Agency (if applicable):	License Number:		
Address:	City:	State:	Zip:	Phone:
Email Address:	Do you accept the claimant's insurance? Yes No			
Supervisor: (if applicable)	Supervisor's email address:			

Client Information:

Name:	CVC Claim number:	Date of Birth:	Relationship to Primary Victim:
Address:	City:	State:	Zip:
Phone:	Living Situation: (i.e., with defendant, foster home, etc.)		
Parent/Guardian name/s:	Insurance Company and coverage information (i.e., deductible, number of sessions covered, etc.)		

Crime Information:

Defendant's Name: (if known)	Relationship to the victim:
What contact does the perpetrator currently have with the victim?	
Police Agency involved:	Type of crime:
Briefly describe the victimization:	

Treatment Planning Section:

1. What symptoms, directly related to the victimization, is the victim/client currently displaying? (physical, psychological, emotional, and behavioral?)
2. Describe the victim's mental health prior to the crime and the impact it may have on current treatment. (Focus of treatment is to be on current crime related injury.)
3. Describe any issues that may increase or decrease the length of treatment or effectiveness of services provided and how these will be handled in treatment.
4. Please describe any current or potential support system your client has.
5. List all treatment goals and objectives relative to the victimization.
6. List the treatment modalities used to achieve these goals.
7. Please mark if therapy sessions will be in person (only): ___ teletherapy (only): ___ or a combination of both in person and teletherapy sessions: ____ ** If Teletherapy sessions are checked, please list the HIPPA approved virtual platform being used (per guidelines in the CVC MH packet) : _____
8. CVC funds are limited and only available to help the victim initiate the recovery from the trauma of the crime. What plans have you made with this client if treatment needs exceed this support?

Estimated number of sessions:

Note: The crime victim compensation Board may award up to **40** (total) sessions for a primary victim and up to **25** (total) sessions for a secondary victim.

Primary victims may be eligible for an extension. Secondary victims are not eligible for an extension of therapy through this program.

All sessions should be used within 1 year of award

Date of your first session with the victim:

Number of sessions to date:

Number of sessions you would like the CVC Board to consider:

_____ - Individual Sessions – Primary Victim (**Sessions must be a minimum of 45 minutes in duration to be CVC compensable**) *Note: Secondary victims/immediate family members of a deceased victim in a homicide may request the same number of sessions as a primary victim.*

_____ - Individual Sessions – Secondary Victim (**Sessions must be a minimum of 45 minutes in duration to be CVC compensable**)

_____ - Group sessions (\$40/session) – must be included in treatment plan above.

***New fee structure is effective for sessions beginning 5/1/2023: \$100/session for unlicensed provider with supervision of licensed provider, \$130/session for licensed provider (see list in MH packet), and \$150/session for licensed psychologist.**

**** EMDR, Micro-current Neurofeedback (MCNF), Neurofeedback (NF), etc. sessions should be included in the total number of individual sessions selected above.**

Signature Section:

I understand, swear, and affirm that under penalty of perjury the following statements are true and correct to the best of my knowledge and belief.

- The treatment plan submitted, and subsequent treatment billed to CVC is directly related to the crime in which the claim has been approved.
- The CVC Board will not be billed for missed/cancelled appointments, trial attendance, report writing, couples counseling, or any session not directly related to the crime in which the claim has been approved.
- Crime Victim Compensation is, by law, the payor of last resort. If insurance is available, invoices must be submitted to the insurance company first.
 - Please include a copy of the Explanation of Benefits (EOB) for each session along with invoices that have been billed to insurance.
 - If insurance is available but is not going to cover services, a letter of denial or explanation of coverage limitations must be provided.

Victim/Guardian Printed Name	Victim/Guardian Signature	Date
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Mental Health Provider Printed Name	Mental Health Provider Signature	Date
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Please submit this treatment plan with signatures (required) to:

Email: da-cvc@jeffco.us
Fax: 303.271.6785
Mail: First Judicial District Attorney
Attn: Crime Victim Compensation Board
500 Jefferson County Parkway
Golden, CO 80401

*Updated 5/1/2023