**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:Click to enter text | Agency (if applicable):Click to enter text | License Number:Click to enter text |
| Address:Click to enter text | City:Click to enter text | State:Enter State | Zip:Enter Zip | Phone:Click to enter text |
| Email Address:Click to enter text | Do you accept the claimant’s insurance?  Yes [ ]  No [ ]  |
| Supervisor: (if applicable)Click to enter text | Supervisor’s email address:Click to enter text |

**Client Information:**

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

**Perpetrator/Crime Information:**

|  |  |
| --- | --- |
| Defendant’s Name: (if known)Click to enter text. | Relationship to the victim:Click to enter text. |
| What contact does the perpetrator currently have with the victim?Click to enter text. |
| Briefly describe the victimization: Click to enter text. |

**Treatment Planning Section:**

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| 1. What symptoms, directly related to the victimization, is the victim/client currently displaying? (physical, psychological, emotional, and behavioral?)

Click to enter text. |
| 1. 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.)

Click to enter text. |
| 1. 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.

Click to enter text. |
| 1. Please describe any current or potential support system your client has.

Click to enter text. |
| 1. List all treatment goals and objectives relative to the victimization.

Click to enter text. |
| 1. List the treatment modalities used to achieve these goals.

Click to enter text. |
| 1. 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) : Click or tap here to enter text. |
| 1. 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?

Click to enter text.  |

**Estimated number of sessions:**

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| **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. **5** family sessions can be requested only on the primary victims’ claim (on or after 5/1/2024).Primary victims may be eligible for one extension of maximum 15 sessions (must be requested on MH Extension Request Form). Secondary victims are not eligible for an extension of therapy through this program.\*All sessions should be used within 1 year of approval\*   |
| Date of your first session with the victim:Click or tap to enter a date. | Number of sessions to date:Click to enter text. |
| **Number of sessions you would like the CVC Board to consider:**Choose a number from drop down - Primary Victim – Individual Sessions **(Maximum of 40)** *Note: Secondary victims/immediate family members of a deceased victim in a homicide may request the same number of sessions as a primary victim.* Choose a number from drop down - Secondary Victim – Individual Sessions **(Maximum of 25)**Choose a number from drop down - Family Sessions – **Limited to five (5) sessions** and can only be requested on the primary victim’s treatment plan. Choose a number from drop down - Group sessions (up to $90/session) – must be included in the treatment plan above. |

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| **VICTIM/CLIENT SIGNATURE SECTION:** |
| I have reviewed the Treatment Plan with my therapist and agree with this plan and the estimated number of sessions.I understand that the CVC Board approves therapy sessions related to the crime for which I have applied, and which is part of the above submitted treatment plan. Treatment for anything other than the crime for which I have applied cannot be paid by CVC.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Victim/Client or Parent/Guardian Signature Date |
| **THERAPIST SIGNATURE SECTION** |
| I have read and understand the Mental Health Provider Guidelines as provided to me by the 1st Judicial District Crime Victim Compensation Program.I agree to only bill for sessions and services that are allowable pursuant to the Bylaws and Policies of the 1st Judicial District and outlined in the Mental Health Provider Guidelines.I understand that CVC 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 CVC for sessions that are related to the crime for which my client has applied, and which are part of the above submitted treatment plan.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Therapist Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Supervising Therapist Signature Date |

**Please submit this treatment plan with signatures (required) to:**

**Email:** da-cvc@jeffco.us

**Fa**x: 303-271-6785

**Mail:** Colorado First Judicial District Attorney

Attn: Crime Victim Compensation Board

500 Jefferson County Parkway

Golden, CO 80401

\*Updated 5/1/2024