20TH JUDICIAL DISTRICT CRIME VICTIM COMPENSATION
Office of the District Attorney, 1035 Kimbark St., Longmont, CO 80501
Phone: 720.564.2835 Fax: 303-416.8721
Email: victimcomp@bouldercounty.gov
Additional forms can be obtained at www.bouldercounty.org/da

INITIAL ASSESSMENT AND MENTAL HEALTH TREATMENT PLAN

All treatment forms ***MUST*** be typed, handwritten forms and forms without required signatures will be returned.

All treatment plans **MUST** be signed by the therapist (supervisor if applicable) and victim/claimant-guardian.

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 of the amount that the Board has set aside for future sessions. Any unused portion of the authorization will revert to the fund one year after approval of the authorization. In addition, if you are submitting this treatment plan prior to the Board's approval of your client's application, the completion of this form does not guarantee approval of funds.

If an application is approved, the Crime Victim Compensation Board reserves the right to request a progress report or the therapist's notes at their discretion. ***Note: This treatment plan may be subject to discovery in court proceedings.***

Client Name: ____

Phone: ____________________________

Mailing 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:

____

Check One: ☐ Primary Victim ☐Secondary Victim

Therapist Name: __________________________________

Email: _________________________ Phone: ___________

Mailing Address:____

Provider state license number: ________________________________
(Please attach a copy of license)

Check 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 name of your supervising therapist and their license number:

___________________________ ______________________
Supervisor Therapist's Name *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, and self-defense or massage therapy)? *Please note: Before consideration can be made by the Board for these types of services you must submit a separate referral letter for your client.*

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.

CVC will pay a maximum of $100.00* per individual session and/or $50.00 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. This is necessary to preserve the limited funds that are available and to maintain equitable compensation among those we serve. (*Rate change effective 04/2023.)

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 your client's out of pocket amount as indicated by insurance.

1. Below, please provide an estimated of the number of sessions requested:

    A. Individual sessions: ___________

    B. Family sessions (**must include primary victim**): _________

    C. Group sessions: ________

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.)

    Anticipated termination date: __________________

4. 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: ___________________ Co-Pay: ____________

Complete insurance documentation (Explanation of Benefits, denials letters, etc.) must be submitted before bills can be processed.]

I, understand, swear, and affirm 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 Crime Victim Compensation is directly related to the crime in which the claim has been approved.***
- ***The Crime Victim Compensation Board will not be billed for missed/cancelled appointments, court ordered treatment, court attendance, report writing, couples counseling, professional consultations or any session not primarily related to the crime in which the claim has been approved.***
- ***Crime Victim Compensation is, by state law, the payer of last resort.***
- ***I will apply for any primary insurance benefits if applicable.***
- ***I shall reimburse the fund up to the total amount of compensation benefits paid which in fact were covered by other means.***
- ***The claimant is responsible for any sessions/charges not compensable through Victim Compensation.***

____________________ ____________________________________

Date *Therapist's signature ***(required)***

____________________ ____________________________________

Date Supervisor's signature (if applicable)

____________________ ____________________________________

Date *Client's/Guardian's signature ***(required)***