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
Website: https://www.bouldercounty.gov/district-attorney/
Email: victimcomp@bouldercounty.gov

Initial Assessment & Mental Health Treatment Plan

To Mental Health Service Provider:

All treatment forms **MUST** be typed.
All treatment plans **MUST** be signed by the therapist (and supervisor if applicable.)
Handwritten forms and forms without required signatures will be returned.
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 (CVC) 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 CVC Program, authorizing six (6) mental health sessions to allow you to 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 email/mail regarding how many additional sessions are authorized. Any unused portion of the authorization will revert back 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 CVC 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 Information

Client Name: ______________________________

Phone: ______________________________

Address: ______________________________

Client Date of Birth: ______________________________

Parent/Guardian Name (if child): ______________________________

Is the client a primary or secondary victim: ☐ Primary ☐ Secondary

Therapist Information

Therapist Name: ______________________________

Phone: ______________________________

Address: ______________________________

Email: ______________________________

State License Number:
(please attach copy of license) ______________________________

Credentials:

☐ M.D. ☐ Ph. D. ☐ M.A. ☐ M.S. ☐ M.S.W. ☐ OTHER ______________________________

The 20th Judicial District CVC 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 Name (if unlicensed): ______________________________

Supervisor License Number: ______________________________

Experience

If you have not worked with the Crime Victim Compensation Program before please fill out the following questions and **also submit a copy of your resume and current license with this form**:

Describe in detail education and experience related to crime victims:

Child/adolescent experience (if applicable):

Perpetrator Information

Perpetrator Name (if known): ______________________________

Relationship to Victim (if known): ______________________________

Therapist (if known): ______________________________

Current Living Situation (if known): ______________________________

Family Information

Are other family members in treatment: Yes No

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

Treatment Information

Behavioral/emotional symptoms directly relating to the victimization is the client is currently displaying:

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.:

Substance-use concerns concerning the client? ☐ Yes ☐ No

If yes, what is the plan for treatment:

Treatment goals/objectives (please state if treatment is specifically related to crime or unrelated):

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

What treatment referrals are being made **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 & Projected Length

CVC 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 $125.00* per individual session and/or $55.00 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. (*Rate change effective 4/1/2025.)
Your client must provide you with information on how to bill his/her insurance company, if coverage is available. *You may then bill CVC for your client's out of pocket amount as indicated by insurance.

Estimated Individual Sessions: ____________________

Estimated Family Sessions: ____________________

Estimated Group Sessions: ____________________

Frequency of Sessions: ____________________

If this is a client you have been treating prior to the crime, please give date of first session dealing primarily with victimization issues.

Date of First Session: ____________________

Anticipated Termination Date: ____________________

Client Insurance Available: ☐ Yes ☐ No

If Yes:

Insurance Company Name: ____________________

Insurance Company Phone Number ____________________

Deductible: ____________________

Co-pay: ____________________

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

Understanding and Signature of Therapist/Supervisor/Client:

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

- Therapist (supervisor if applicable) and client have reviewed this Extension Request and agree with it along with estimated number of sessions and treatment cost.
- The Treatment Plan submitted and treatment billed to Crime Victim Compensation is directly related to the crime in which the claim has been approved.
- The CVC Board will not be billed for missed/cancelled appointments, court ordered treatment, court attendance, report writing, couples counseling, professional consultations/sessions involving the offender or any session not primarily related to the crime in which the claim has been approved.
- CVC 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 client/parent/guardian is responsible for any sessions/charges not compensable through CVC.

______________________________ ____________________

Therapist Signature (required) Date

______________________________ ____________________

Supervisor's Signature (required if treating therapist is unlicensed.) Date

______________________________ ____________________

Client/Guardian Signature (if client is under 18, parent/guardian must sign.) Date