21ST JUDICIAL DISTRICT
CRIME VICTIM COMPENSATION BOARD

Victim Compensation Board
Department 5031
P.O. Box 20,000
Grand Junction, Colorado, 81502

Telephone: 970-244-1737
Fax: 970-256-1549

MENTAL HEALTH THERAPY INITIAL TREATMENT PLAN FORM

Prior approval for crime related mental health treatment and/or submission of this form does not guarantee payment of additional mental health treatment services. You will be notified in writing of all Board decisions. All treatment costs exceeding the approved amount determined by the Board are the responsibility of the claimant. This form may be emailed to you for convenience. Hand written forms will not be processed and will be returned.

CLIENT INFORMATION:

Name: _____ DOB:_____
Address: _____
City/State/Zip: _____
Client's Parent/Legal Guardian (if under 18): _____

THERAPIST INFORMATION:

Name: _____ License No._____
Business Address: _____
City/State/Zip: _____
Telephone Number: _____ Fax Number: _____
Email: _____
Supervisor Name:_____ License No._____

CLIENT TREATMENT INFORMATION:

Date Treatment Began: _____ Number of Sessions to Date: _____
Date of Crime: _____ Type of Crime: _____
Is the presenting issue related to the crime listed above? ____ No ____ Yes

Treatment Modalities to be Used:
____ Individual ____ Group ____ Other:_____

1. Please describe the behavioral and emotional symptoms currently displayed by the victim:

2. Please list any pre-existing mental health issues exacerbated or discovered due to the crime against the victim:

3. List the treatment goals/objectives relative to the victimization (each goal should have an estimated completion date; please include safety planning and education as appropriate.):

   a.

   b.

   c.

Goals/ Continued from Previous Page:

d.

e.

4. List any treatment goals/objectives unrelated to the victimization (How will preexisting issues be addressed?):
   a.
   b.
   c.

5. Please identify any factors which may impede your treatment during the next six months:

6. Based on the information presently available, what is your rating of this patient's prognosis for resolution of the concerns for which you were consulted?

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

7. Projected number of treatment sessions: _____
8. Frequency of therapeutic contacts: _____
9. What is your anticipated date of discharge with this patient? _____

CLIENT INSURANCE INFORMATION:

Does the Victim have insurance? ☐ No ☐ Yes If 'Yes', will you be accessing the insurance? ☐ No ☐ Yes

If 'No', why? _____

Company Name:_____

Policy Number: _____ Group Number: _____

I understand that Crime Victim Compensation is, by state law, the payor of last resort, and I further agree to apply for any primary insurance benefits of my client, if eligible. I understand that Crime Victim Compensation can only pay for the client's out of pocket amount as indicated by insurance. I further agree to only bill Crime Victim Compensation for sessions that are part of the above submitted treatment plan. I agree not to bill Crime Victim Compensation for treatment outside of the above treatment plan.

The information contained herein is correct to the best of my knowledge, information and belief. I understand and agree to the following:
I am a licensed therapist, or under the supervision of, who has experience working with trauma victims.

I will accept the **Board's** hourly reimbursement of **$80** for individual therapy and **$35** for group therapy as payment in full; and, I will request any necessary extension 30 days prior to the termination date of any award made.

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

_____ _____
Therapist Signature Date

_____ _____
Therapist Supervisor Signature Date

_____ _____
Client/Guardian Signature Date

Once the Board has made an approval you will be notified in writing. The Board processes and issues payments only once a month, therefore payment could take up to 30 days after receiving an itemized bill/invoice.