

# Mental Health Treatment Plan

## Crime Victim Compensation

First Judicial District  
500 Jefferson County Parkway  
Golden, CO 80401  
Phone: 303.271.6846  
Fax: 303.271.6785

**Victim Claim #:** \_\_\_\_\_

Approval of initial therapy or submission of this form does not guarantee payment of continued treatment. Any and ALL treatment costs exceeding the approved amount determined by the Board are the responsibility of the claimant. The client will be notified by mail of all Board decisions. Due to the number of treatment plans reviewed by the Board each month, you are required to enter this form into a word processing program. **Handwritten forms will be returned without being reviewed.**

### **THERAPIST INFORMATION SECTION:**

Name:  
License #:  
Address:  
City/State/Zip:  
Telephone Number:  
Provider Email Address (must include):

Supervisor:  
License #:  
Address:  
City/State/Zip:  
Telephone Number:

### **CLIENT INFORMATION SECTION:**

Name:  
Address:  
Date of Birth:  
Police jurisdiction where the crime occurred:

Parent/Guardian:  
Primary Claim# (if applicable):

### **FAMILY INFORMATION SECTION:**

List family members that will be involved in treatment related to the victimization and respective therapist name (sessions involving the defendant/perpetrator will not be covered):

What is the reaction of the victim's family to the victim, perpetrator, and the crime in general?

### **PERPETRATOR INFORMATION SECTION:**

Name:  
Relationship to victim:  
What contact does the perpetrator currently have with the victim/client?

### **TREATMENT PLANNING SECTION:**

1. Briefly describe victimization.

2. What behavior and emotional symptoms directly related to the victimization is the victim/client currently displaying?

3. Describe the victim's mental health prior to the crime and the impact it may have on current treatment.

4. List the treatment goals and objectives relative to the victimization.

5. List treatment modalities used to achieve these goals.

6. Describe any issues that may increase or decrease the length of treatment or effectiveness of services provided.

**ESTIMATED LENGTH OF TREATMENT SECTION:**

Date client entered treatment: \_\_\_\_\_ Number of sessions to date: \_\_\_\_\_

Number of sessions you would like to Board to consider:

\$90 per individual session at \_\_\_\_\_ (number of) sessions  
\$135 per 1.5 hour EMDR session at \_\_\_\_\_ (number of) sessions  
\$40 per group session at \_\_\_\_\_ (number of) sessions

**INSURANCE INFORMATION SECTION:**

I am a provider for my clients insurance? Yes/No

Company: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Type of Mental Health Coverage:

Number of Sessions Allowed:

Policy Number:

\*Please include a copy of the Explanation of Benefits (EOB) with invoices that have been billed to insurance. If insurance is available but is not going to cover services, a letter of denial or phone call to the Compensation Program must be provided.

**SIGNATURE OF CLAIMANT SECTION:**

Is the victim/client aware of and in agreement of this treatment plan and estimated number of sessions and cost?

\_\_\_\_\_  
Victim/Client or Parent/Guardian Signature (required for payment)

\_\_\_\_\_  
Date

**SIGNATURE OF THERAPIST SECTION:**

I have read and understand the Mental Health Guidelines as provided to me by the 1st Judicial District Crime Victim Compensation Program. I agree to bill for only the sessions and services which are allowable pursuant to the Policies of the 1st Judicial District and outlined in the Mental Health Guidelines. I understand that Crime Victim Compensation 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 Crime Victim Compensation for sessions that are related to the victimization of the criminal incident for which my client has applied and which are part of the above submitted treatment plan.

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Supervising Therapist