CRIME VICTIM COMPENSATION BOARD
EIGHTEENTH JUDICIAL DISTRICT
6450 S. REVERE PKWY
CENTENNIAL, COLORADO 80111
720-874-8787
VictimComp@da18.state.co.us

VICTIM COMPENSATION TREATMENT PLAN

HANDWRITTEN FORMS WILL NOT BE ACCEPTED

NOTE: Completion of this form **does not** constitute approval of this claim and should not be viewed as such. Please complete the information requested below. Incomplete treatment plans will be returned without being reviewed.

DATE:

CLIENT INFORMATION:

Name: **Parent/Guardian:**
Address:

Telephone No:

Current living situation:

THERAPIST INFORMATION:

Name/Agency:
Address:

Telephone No:
License No & Type:

Supervisor:
Address:

Telephone No:
Supervisor License No & Type:

INSURANCE INFORMATION:

Does the client have insurance?
Company:
Telephone No:
Policy No:

Type of Mental Health Coverage: (Prior to any payment, a copy of coverage specific to benefits available, denied, deductible, co-pay or percentage insurance will pay per visit, per calendar year **must be returned**.)

TREATMENT:

1. **Briefly describe the victimization. Include date of crime, name of perpetrator, and reporting law enforcement agency.**

2. **Describe the client's current symptomology that is directly related to his/her victimization.**

3. **What are the treatment goals related to his/her victimization? Please be as specific and detailed as possible.**

   a)

   b)

   c)

4. **Treatment modalities used to achieve these goals (check all that apply).**

☐Individual	☐Play Therapy
☐Family	☐Sand Tray Therapy
☐Group	☐ Neurofeedback
☐Couples	☐ Animal Assisted Therapy
☐EMDR	☐Other -

5. **Describe any issues that may affect length of treatment or effectiveness of therapy. Be as detailed as possible (examples: court involvement, previous victimization, prior mental health counseling, health concerns, etc.).**

Please complete the section below:

****PLEASE NOTE: The board will consider no more than 20 sessions at a time.**

 # individual / family therapy sessions needed to complete therapy at $90 per session.

 # group therapy sessions needed to complete therapy at $40 per session.

 # individual / family therapy sessions needed to complete therapy at $45 **intern** rate per session.

Frequency of sessions:

☐ 1x a week ☐ Other – please explain –

$_____ **TOTAL ANTICIPATED COST OF TREATMENT**

ADDITIONAL INFORMATION:

If so desired, please include additional information.

Both the claimant and the therapist must sign this form.

Claimant Signature	Date	Therapist Signature	Date

Please return completed forms to:
Victim Compensation Board
6450 S. REVERE PKWY
Centennial, Colorado 80111
Fax: 720-733-4697
VictimComp@da18.state.co.us