

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:** Click here to enter text.

## CLIENT INFORMATION:

Name: Click here to enter text. Parent/Guardian: Click here to enter text.

Address: Click here to enter text.

 Click here to enter text.

Telephone No: Click here to enter text.

Current living situation: Click here to enter text.

## THERAPIST INFORMATION:

Name: Click here to enter text. Supervisor: Click here to enter text.

Agency: Click here to enter text. Agency: Click here to enter text.

Address: Click here to enter text. Address: Click here to enter text.

 Click here to enter text. Click here to enter text.

Telephone No: Click here to enter text. Telephone No: Click here to enter text.

License No & Type: Click here to enter text. Supervisor License No & Type: Click here to enter text.

## INSURANCE INFORMATION:

### Does the client have insurance? Choose an item.

Company: Click here to enter text.

Telephone No: Click here to enter text.

Policy No: Click here to enter text.

Type of Mental Health Coverage (Please include deductible amount and percentage insurance will pay per visit, per calendar year.)

Click here to enter text.

## TREATMENT:

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

 Click here to enter text.

1. Describe the client’s current symptomology that is directly related to his/her victimization.

 Click here to enter text.

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

1. Click here to enter text.
2. Click here to enter text.
3. Click here to enter text.
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 - Click here to enter text.

1. 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.).

 Click here to enter text.

**Please complete the section below:**

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

Choose an item. **# individual / family therapy** sessions requested at $90 per session.

Choose an item. **# group therapy** sessions requested at $40 per session.

*Choose an item.* **# INTERN individual / family therapy** sessions requested at $45 per

 session.

Frequency of sessions:

[ ]  1x a week

[ ]  Other – please - Click here to enter text.

\_\_\_$\_Click here to enter text.\_\_\_\_ **TOTAL ANTICIPATED COST OF TREATMENT**

ADDITIONAL INFORMATION:

If so desired, please include additional information.

Click here to enter text.

**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