Crime Victim Compensation Board

Twenty-Third Judicial District of Colorado

PHONE: (720) 733 - 4580

FAX: (720) 733 - 4672

EMAIL: DAVICTIMCOMP@CODA23.GOV

PROUDLY SERVING DOUGLAS, LINCOLN AND ELBERT COUNTIES

Initial Treatment Plan

PLEASE COMPLETE ALL FIELDS. INCOMPLETE OR HANDWRITTEN TREATMENT PLANS WILL NOT BE REVIEWED.

NOTE: Completion of this form does not guarantee approval of a claim. Due to claim volume, treatment plans typically take 30-45 days to process.

SECTION 1 – CLIENT INFORMATION

Client Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Mailing Address: _____

City: _____ State: _____

Zip Code: _____

Telephone Number: _____

Client's current living situation: _____

Is this client the primary victim? ☐ YES ☐ NO

SECTION 2 – THERAPIST INFORMATION

Therapist Name: _____

Agency: _____

Mailing Address: _____

City: _____ State: _____

Zip Code: _____

CONTINUED ON NEXT PAGE

Telephone Number: _____

Email: _____

License Number: _____ License Type: _____

SECTION 3 – SUPERVISOR INFORMATION

Only complete this section if you are unlicensed or an intern. Check not applicable if you do not require supervision.

☐ NOT APPLICABLE

Supervisor Name: _____

Agency: _____

Telephone Number: _____

Email: _____

License Number: _____ License Type: _____

SECTION 4 – CLIENT INSURANCE INFORMATION

THIS SECTION IS ***REQUIRED***. As the payor of last resort, Crime Victim Compensation must document all collateral sources of payment even if you are unable to bill the client's insurance.

Does the client have insurance? ☐ YES ☐ NO

Insurance Provider: _____

Policy Number: _____

Telephone Number: _____

Are you paneled with the client's insurance provider? ☐ YES ☐ NO

Deductible Amount: _____

Client's co-pay after deductible is met: _____

SECTION 5 – TREATMENT

5.1) Briefly describe the victimization as reported by the client. Include the date of crime, name of the offender, and the law enforcement agency the crime was reported to:

CONTINUED ON NEXT PAGE

5.2) Describe the client's current symptomology as it directly relates to their victimization:

5.3) What are the client's goals in treatment as it relates to their victimization? Be as detailed as possible:

Goal 1:

Goal 2:

Goal 3:

CONTINUED ON NEXT PAGE

5.4) List all treatment modalities that will be utilized in working toward these goals:

5.5) Are there any issues known to the therapist that may affect the length or effectiveness of treatment? If yes, please explain:

5.6) What is the anticipated frequency of sessions? If the client will be attending more than one session per week, please explain:

5.7) Is there any additional information you would like the Board to consider?

SECTION 6 – REQUEST FOR SESSIONS

NOTE: The Board will NOT consider more than 25 sessions at one time. A request for group sessions must be made on a separate treatment plan form.

_____ Number of Individual/Family Sessions: $120.00/hour

_____ Number of Individual/Family Sessions INTERN Rate: $60.00/hour

_____ Number of Group Sessions: $40.00/hour

TOTAL COST OF TREATMENT: _____

CONTINUED ON NEXT PAGE 4

REVIEW AND SIGN

This form must be signed by the client (or parent/guardian if the client is under the age of 18), the therapist, and the therapist's supervisor if applicable. Unsigned forms will be returned to the therapist and may result in delays in processing.

_____

Client Signature Date

_____

Therapist Signature Date

_____

Supervisor Signature Date

PLEASE RETURN COMPLETED FORMS TO:
OFFICE OF THE DISTRICT ATTORNEY
C/O CRIME VICTIM COMPENSATION
4000 JUSTICE WAY, SUITE 2525A
CASTLE ROCK, CO 80109
EMAIL: DAVictimComp@coda23.gov
FAX: (720) 733 - 4672