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: Supervisor:
Agency: Agency:
Address: Address:

Telephone No: Telephone No:
License No & Type: Supervisor License No & Type:

INSURANCE INFORMATION: (Must be completed even if no insurance accepted)

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

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

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
   ☐Family
   ☐Group
   ☐Play Therapy
   ☐Sand Tray Therapy
   ☐ 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 25 sessions at a time for new claims on/after September 1, 2023 (20 sessions at a time for claims prior to September 1, 2023).

Reimbursement rates listed are only applicable to treatment sessions on/after September 1, 2023.

_____ **# individual / family therapy** sessions requested at $120 per session.

_____ **# group therapy** sessions requested at $50 per session.

_____ **# INTERN individual / family therapy** sessions requested at $60 per session.

Frequency of sessions:
☐ 1x a week
☐ Other –

___$_____ **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