19TH JUDICIAL DISTRICT

WELD COUNTY CRIME VICTIM COMPENSATION PROGRAM

INITIAL TREATMENT REPORT FORM

* To expedite the process, mental health providers should keep copies of this form along with the Authorization to Release and Obtain Information on file and should not wait for notices concerning the submission of reports.

* Submit a **SEPARATE REPORT FORM FOR EACH INDIVIDUAL TREATED**.

* Forms can be sent electronically upon request in a Microsoft Word document.

*** Typed forms are required. Illegible or incomplete forms will slow processing. Handwritten forms will be returned without being reviewed by the Board.**

CLIENT INFORMATION:

Name:_____ DOB: _____Age:_____

Parent/Guardian:_____

Related Client Name(s)/Relationship to claimant (sessions involving defendant/perpetrator will not be covered):

_____

_____

Health Insurance: ☐ Yes ☐ No Medicare/Medicaid: ☐ Yes ☐ No Co-pay $:

Are you an eligible mental health provider, either in-network or out of network, for this claimant's insurance? ☐ Yes ☐ No

Note: Crime Victim Compensation is the payer of last resort. Complete insurance documentation (e.g. EOBs, denial letter, etc.) must be submitted before bills can be processed. Please be aware that one of the funding sources for the Crime Victim Compensation fund is through restitution, which is frequently court-ordered to be paid back into the fund by the defendants in these cases. Please advise clients that restitution may be sought from the defendant for their treatment.

THERAPIST INFORMATION:

Name/Degree:_____ Agency:_____ Lic. No.: _____

Mailing Address:_____ Ph.:_____

E-Mail: _____

CLINICAL SUPERVISOR INFORMATION:

Name/Degree: _____ Lic. No.:_____

Mailing Address:_____ Ph.: _____

CLIENT TREATMENT INFORMATION:

1. Today's Date: _____ 2. Date treatment began:_____

3. Type of Crime: _____ 4. Date of Crime: _____

5. Is the presenting issue related to crime listed above? ☐ Yes ☐ No

6. List any pre-existing mental health issues not related to the crime that may affect treatment and how these will be addressed (**focus of treatment must be on current crime related injury**).

7. What is the impact of the current victimization (physical, psychological, emotional and behavioral):

8. Describe the victim's mental health, including medications the victim was taking, prior to the crime:

9. List treatment goals and objectives (goals must relate only to the effects of the current victimization). Each goal should have an estimated number of sessions for completion.

a.

Estimated completion date:

b.

Estimated completion date:

c.

Estimated completion date:

10. No. of sessions to date: Individual_____ Group_____ Family_____

11. Treatment modalities to be used: Individual _____ Group _____ Family _____ Other:

12. What other recommendations or treatment referrals might be made (i.e. psychological assessment, evaluation for medication, family therapy, group therapy):

13. Other relevant information the Board should be aware of (e.g. other victimizations, other criminal justice involvements):

14. If treatment needs exceed the limits of the Crime Victim Compensation Program, how will remaining treatment needs be addressed? **NOTE: Claimants who choose to receive services outside of their network provider will be <u>fully responsible for payment</u> once Crime Victim Compensation limits have been met.**

Crime Victim Compensation will not pay for the following: missed/cancelled appointments, trial attendance, report writing, marital counseling, and sessions that are not primarily dealing with issues directly related to the criminal justice incident for which the client is applying. Any lapse of treatment over six months will require a new treatment report and approval from the Board.

I understand that Crime Victim Compensation is, by state law, the payer of last resort, and I further agree to apply for any primary insurance benefits of my client, if eligible. I understand that Crime Victim Compensation can only pay for the client's out of pocket amount as indicated by insurance. I further agree to only bill Crime Victim Compensation for sessions that are part of the above submitted treatment plan. I agree not to bill Crime Victim Compensation for treatment outside of the above treatment plan.

I swear and affirm under the penalty of perjury that the statements herein are true and correct to the best of my knowledge and belief.

Therapist's Signature: _____ Date:_____

Supervisor's Signature: _____ Date: _____

Claimant's Signature: _____ Date: _____

***If client is under age 18, parent or guardian must sign.

-Form Date 5/6/22

Please return completed form to:
Crime Victim Compensation
PO Box 1167
Greeley, CO 80632
Fax (970) 336-7224
weldvictimcompensation@weldgov.com
It is strongly recommended that providers keep copies of completed forms.