CRIME VICTIM COMPENSATION BOARD

Fourth Judicial District
Office of the District Attorney
105 E. Vermijo, Ste 111, Colorado Springs, CO 80903
Office: (719) 520-6000 Fax: (719) 520-6172

INITIAL ASSESSMENT AND TREATMENT PLAN

This form must be typed. Treatment plans that are not typed will be returned to the provider. Please call if you would like a copy emailed to you or you may go to the 4th Judicial District Attorney's Website:

http://www.4thjudicialda.com

This plan will provide information upon which the board members will make decisions concerning compensation funds for this victim. This form **does not** constitute approval of this claim, past the three sessions to develop this treatment plan.

A primary victim of a crime is defined as any person whom a compensable crime is perpetrated or attempted.

A secondary victim of a crime is defined as any person who attempts to assist or assists a primary victim.

This treatment plan may be subject to discovery in court proceedings.

Therapist Information

Name of Therapist: ____

Circle One: M.D. Ph.D. M.A. M.S. M.S.W. OTHER

State Licensed? YES_____ NO ______

License type and #:____

ONLY STATE LICENSED THERAPISTS ARE ELIGIBLE FOR PAYMENT

Address:____

Telephone:______________________________Email:________________________

Victim Information

Check One: ☐ Primary Victim ☐ Secondary Victim

- Victim's Name: ____
- Victim's Age: ____
- Crime: ____
- Approximate date of crime: ______________________________________
- Total number of sessions to date: __________________________________
- Total number of **Victim Compensation Sessions** to date: _________________

Living Situation

- Victim's living situation: ____
- Date victim entered treatment:____________________________________
- Number of sessions to date:______________________________________

Perpetrator Information

- Perpetrator's name: ____
- Perpetrator's relationship to the victim: ______________________________
- Perpetrator's therapist:____
- Perpetrator's current living situation:________________________________

Family Information

- What is the reaction of the victim's family to the victim, perpetrator and the crime in general?
- Names of other family members that are involved in treatment?

Victim Treatment Issues

What behavioral and emotional symptoms directly relating to the victimization are currently being displayed by the victim?

Treatment goals and objectives:

1.

2.

3.

4.

Discuss treatment modalities used to achieve these goals:

What treatment referrals are being made at this time **for primary victim only** (psychological assessment, group therapy, medication evaluation, self-defense or massage therapy)? **Any future referrals will require a letter.**

List any pre-existing mental health issues affected or discovered due to the crime against the victim:

How will these issues be addressed?

Projected Length of Treatment

- Total number of **Victim Compensation Sessions** requested:_________
- Anticipated termination date:_____________
- What circumstances would increase or decrease the projected termination date:
  ____

Insurance

Victim Compensation is the payer of last resort, as such, all health insurance coverage, including Medicaid and Medicare, must be utilized prior to the Victim Compensation program making awards. Please discuss with your client their insurance situation.

**** You should verify if they have seen another therapist for this same crime prior to seeing you because some sessions may already have been utilized and you will need to complete a change of therapist form instead of this form.**

I acknowledge that a failure to follow the policies could result in not being reimbursed for services that were rendered in a manner that does not conform to these policies. I understand that violations of Board Policies could also result in ineligibility to receive future funding from the Crime Victim Compensation Fund.

Therapist Signature:________________________________ Date: __________________

I have read and understand the treatment goals for my continued mental health therapy. I understand that this Initial Assessment and Treatment Plan will be provided to the 4th Judicial District Victim Compensation Board as a request for additional therapy sessions. My signature acknowledges my understanding and will be considered to be in agreement with the request for ongoing therapy.

Patient Signature:_________________________________ Date: __________________

Rev. 10/11; 6/12; 7/13; 3/14; 11/15; 10/16; 3/18