CRIME VICTIM COMPENSATION BOARD
Fourth Judicial District
Office of the District Attorney
105 East Vermijo, Suite 111, Colorado Springs, CO 80903
Office: (719) 520-6000 Fax: (719) 520-6172

CHANGE OF THERAPIST - TREATMENT PLAN

This form must be typed. All forms submitted not typed will be returned to the provider. The victim has requested to change therapists. Please complete this treatment plan for the remaining sessions for which the victim was approved. **There may be outstanding sessions with the previous therapist which have been encumbered for payment.**

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: ________________________________
- Living situation: ____
- Date victim entered treatment: ____________________________

- Total number of sessions to date: ______________________________________
- Why is the victim requesting a new therapist?: ___________________________
- Total number of **Victim Compensation Sessions** to date: ___________________

Perpetrator Information

Perpetrator's name: ____

Perpetrator's relationship to the victim:____

Perpetrator's therapist if known:____

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:

How will progress toward goals be measured?:

What other recommendations or treatment referrals might be made, i.e., psychological assessment, group therapy, psychological evaluation for medication, 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 sessions:
- 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.**

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 Change of Therapist 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: _______________