IDAHO CRIME VICTIMS COMPENSATION PROGRAM

Initial Treatment Plan

CV#: _____ Client's Name: _____

Parent/Guardian: _____ Tax I.D. #: _____

Therapist's Name: _____ Credentials: _____

License #: _____

Name of Supervising Therapist (if applicable): _____

Name of Treatment Facility: _____

Are you a provider under these programs?:

☐ Medicaid ☐ Medicare ☐ TriCare Other _____

☐ Blue Cross ☐ Indian Health Services ☐ Blue Shield

Do you bill on a sliding fee scale? ☐ Yes ☐ No Rate billed for this client? _____

Indicate what sources of payment are available to the client: _____

Date treatment began: _____ Number of sessions to date: _____

1. **Please describe the presenting symptoms or conditions for which the client is seeking treatment.**

2. **Does the client have a history of previous mental health treatment? ☐ Yes ☐ No**
If so, please indicate approximate dates of treatment, reason for the treatment, duration of the treatment and, the results of the treatment.

3. **Was there prior victimization or psychological trauma? ☐ Yes ☐ No If so, please describe.**

4. **Please provide a brief description of the crime as related to you, including the source of the information (i.e. client, parent or other).**

5. **Please describe any pre-existing conditions that may affect treatment, including any recent psychological stressors, and to what extent these conditions may have been exacerbated by the crime**.

6. **Indicate percentage of treatment resulting from pre-existing or non-crime related conditions.** _____ %

7. **Describe the symptoms/conditions you are treating that are a <u>direct</u> result of the crime.**

8. **Indicate percentage of treatment resulting from crime-related conditions.** _____ %
(Percentages from #6 and #8 should equal 100%)

9. **Describe the client's support system and how it will be involved in the treatment.**

10. **DSM IV Diagnosis (indicate the code and the descriptor).**
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

11. **Estimated duration of treatment: from** _____ **to** _____

12. **Estimated cumulative cost of treatment: $** _____

13. **List below the treatment goals for this client, give specific behavioral measures and projected dates to achieve these goals.**

Symptom/Condition	Treatment Goal	Method	Target Date

14. **I certify that the information provided in this treatment plan is true and accurate. I acknowledge that if the alleged offender is convicted, the Program will request the criminal court to order the alleged offender to pay restitution to reimburse the Program for expenses paid on behalf of the victim. I further acknowledge that this document may be submitted as evidence and that I may be called to testify regarding the mental health treatment outlined in this plan.**

Signature of Therapist _____ Date _____

Supervisor's Signature (if applicable) _____ Date _____