IDAHO CRIME VICTIMS COMPENSATION PROGRAM

Mental Health Progress Report

CV#: _____
Client's Name: _____
Parent/Guardian: _____
Client's insurance & member ID: _____
Are you able to bill the Client's insurance: ☐ Yes ☐ No

Therapist Name: _____
Email: _____
Name of Treatment Facility: _____
Period Covering: _____
Estimated length of treatment: _____

1. **Please describe the presenting symptoms/conditions you are treating that are a *direct result* of the crime.**

_____
_____
_____

2. **Please provide information on progress made toward crime related treatment goals.**

_____
_____
_____
_____
_____

3. **In your opinion, what percentage of this treatment is a direct result of the qualifying crime?**

☐ 100% ☐ 75% ☐ 50% ☐ Other _____%

4. **Diagnosis(es): _____**

5. **Please initial the following:**

____ I understand that if the victim's offender is convicted, the Program will request the criminal court to order the offender to pay restitution to reimburse the Program for any expenses paid for this crime. As a treating provider, I acknowledge that this document may be submitted as evidence. Additionally, I may be required to testify in a restitution hearing regarding the mental health counseling services as indicated in this Progress Report.

____ I understand if any sessions include the offender, I will not bill these sessions to the Program, per Idaho Code §72-1016(2).

____ I understand at any time during treatment, the Program may require session notes detailing treatment.

____ I understand that this fully completed and signed form, any applicable Insurance Explanation of Benefits and completed CMS 1500 claim form are required before payment may be made. This Program is not a guarantor for any services delivered.

____ I certify that the information provided in this progress report is true and accurate.

Signature of Therapist: _____ Date: _____

Supervisor Signature (if applicable): _____ Date: _____