IDAHO CRIME VICTIMS COMPENSATION PROGRAM

Mental Health Treatment Plan

CV#: ______________________________
Client's Name: ______________________________
Parent/Guardian: ______________________________
Offender name and relationship (if known): ______________________________
Client's insurance & member ID: ______________________________
Are you able to bill the Client's insurance: _ Yes _ No

Therapist Name: ______________________________
Email: ______________________________
License #: ______________________________
Tax I.D. #: ______________________________
Credentials: ______________________________
Name of Supervising Therapist (if applicable): ______________________________
Name of Treatment Facility: ______________________________
Do you bill on a sliding fee scale? ______________________________
Date treatment began: ______________________________
Estimated length of treatment: ______________________________

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

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

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

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

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

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

☐ 100% ☐ 75% ☐ 50% ☐ Other ______%

7. Diagnosis(es): ____

8. 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 treatment plan.

____ 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, my initial treatment assessment/intake, 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 treatment plan is true and accurate.

Signature of Therapist: ____ Date:____________

Supervisor Signature (if applicable): ____ Date: ___________