IDAHO CRIME VICTIMS COMPENSATION PROGRAM

Family Assistance Treatment Plan

CV#: _____

Primary Victim's Name _____

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: _____

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.**

_____

_____

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).**

_____

_____

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

☐ 100% ☐ 75% ☐ 50% ☐Other _____%

4. **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, 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: _____

Under Idaho Code 72-1019(9), the Program can provide assistance for mental health treatment for family members of victims who are killed as a result of the crime, kidnapped, sexually assaulted, or are the victims of domestic violence.