Additional Treatment Plan (Form) - Continuing Treatment

(Confidential)

State of California **Treatment Plan** VCGCB-VOC-6025 *(Revised 10-10-06)*	**California Victim Compensation and Government Claims Board (Board)**

Return Form To:	Claim Number:	Date Form Sent:
Victim Compensation Program **P.O. Box 591** **Sacramento, CA 95812-0591**	Victim's Name:	
	Claimant's Name:	
Or Your Local Victim/Witness Assistance Center Verification Unit	Incident Date:	

This form must be completed if your client has reached the mental health benefit service limitations noted below and additional treatment is necessary as a direct result of the crime. No payment for the additional sessions will be authorized until the Additional Treatment Plan is reviewed and approved. You will be notified by mail of the result of the review. Further requests for additional treatment will be reviewed and may require additional information. This may include session notes or objective assessments of impairment, which may be needed to evaluate or verify this request for additional treatment.

Mental Health Benefit Service Limitations *(Please check the appropriate box)*

Service Limitation	Client/Patient	Requirements
40 Session Hours	☐ Direct Victim	Complete Entire Treatment Plan
30 Session Hours	☐ Direct Victim of Unlawful Sexual Intercourse *(Penal Code, section 261.5(d))* ***(Not to exceed the statutory $3,000.00 outpatient mental health limit)*** ☐ Surviving parent, sibling, child, spouse, registered domestic partner, or *fiancé (fiancée) of a homicide victim ☐ Derivative Victim that is scheduled to testify as a witness in criminal proceedings related to the qualifying crime **Must have witnessed the crime*	Complete Entire Treatment Plan
	☐ Derivative Minor Victim (minor at the time of the crime) ***(Not to exceed the statutory $3,000.00 outpatient mental health limit)*** ☐ Derivative Victim who was the Primary Caretaker of a Minor Direct Victim at the time of the crime (for up to two primary caretakers)	Complete Questions 1 thru 11, Question 23b and Questions 24 thru 29 ONLY
15 Session Hours	☐ *Derivative Victim (Adult) *A derivative victim eligible in more than one category may use only the most favorable category	Complete Questions 1 thru 11, Question 23b and Questions 24 thru 29 ONLY

Session Calculations (Individual/Family Therapy)

Individual/Family:	Session Hour = 1 Session	Group:	1 Session Hour = .5 (1/2) Session

As required by law, the information requested must be returned to the Victim Compensation Program (Program) within ten (10) business days and must be provided at no cost to the client, the Program, or local Victim/Witness Assistance Centers. The Program certifies that there is a signed authorization on file for the release of the information requested. Please answer questions fully and complete the signature page at the end of the document. Use additional pages if necessary. Failure to complete this form may result in a delay or denial of payment.

1. Name of Client:
2. Name of Victim:
3. Client's Relationship to Victim:

4. Name of Therapist:		
5. Provider Organization Name:		
6. License/Registration Number and Expiration Date		
7. Mark Appropriate Box for Title of Licensed/Registered Therapist (refer to #6)		
LMFT LCSW Licensed Clinical Psychologist Psychiatrist	Registered Psychological Assistant LMFT Intern ASW	Registered Psychologist Resident in Psychiatry Other (Please specify):
8. Name and Title of Supervising Therapist (If applicable):		
9. License Number:	10. Expiration Date:	

11. Have there been any significant changes in your understanding of the crime(s) for which this client is receiving treatment? If yes, please explain:

☐ No Significant Changes

12. Have there been any changes in Axes 1-4 as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial diagnosis that you previously completed for this client? If yes, please explain:

☐ No Changes

13a. Please rate this client's impairment level in the following areas:

GAF (Axis V) __________

SOFAS __________

GARF __________

13b. If any of the impairment level scores are lower than the scores on your previous treatment plan(s), please explain.

14. Have there been any event(s) since the last treatment plan you submitted which have made a significant impact on the course of your treatment? If yes, please describe:

☐ None

15. Did this client have to testify as a witness in any criminal or dependency proceeding related to the crime?
   - ☐ Yes – If "yes", please provide the date of the court proceeding: ________________________________
   - ☐ No

16. Was the perpetrator of the crime released from custody?
   - ☐ Yes – If "yes", please provide the date the perpetrator was released from custody: ____________________________
   - ☐ No
   - ☐ N/A

TREATMENT PLAN

17. What symptoms/behaviors have been the focus of your treatment since you completed this client's last treatment plan? On a scale from 1 to 9, with 1 representing the lowest score and 9 the highest, please rate the effectiveness of the intervention for each symptom/behavior using the scale below.

1. Symptom/Behavior:

Worsened 1 2 3	Remained Relatively the Same 4 5 6	Improved 7 8 9	Rating

2. Symptom/Behavior:

Worsened 1 2 3	Remained Relatively the Same 4 5 6	Improved 7 8 9	Rating

3. Symptom/Behavior:

Worsened 1 2 3	Remained Relatively the Same 4 5 6	Improved 7 8 9	Rating

4. Symptom/Behavior:

Worsened 1 2 3	Remained Relatively the Same 4 5 6	Improved 7 8 9	Rating

18. Please list below any symptoms/behaviors that will be added as a focus of your treatment if additional sessions are awarded.

19. Please describe the interventions you plan to use to address the symptoms/behaviors listed above (if you have already described the intervention for this symptom/behavior and plan no changes, write “same”):

20. What additional factors that were not present in the previous plan, or other changes in the case, will improve the likelihood of the client’s recovery?

21. Has this treatment plan been discussed with and consented to by the client or the client’s caretaker?
_____Yes ______No

22. If this client is a minor, is a primary caretaker(s) involved in the treatment, and if so, what is the nature and extent of that involvement?

☐ Not a minor

23a. Please indicate below the date your treatment began and the sessions that you have completed with this client. Please include all sessions to the present date:

Date treatment began:

Individual sessions completed:_________________________	Conjoint sessions completed:________________________
Family sessions completed: __________________________	Group sessions completed:__________________________

23b. Percentage of treatment completed:_____________

24. Have you, or do you plan to use any standardized, objective measures to assess the progress of your client’s treatment?

☐ No
☐ Yes. Please specify the tests you expect to use:

25. Please describe why the treatment you are proposing is necessary for the recovery of the direct victim(s):

26. What symptoms/behaviors exhibited by the direct victim will be the focus of your treatment for the derivative victim?

27. What intervention(s) do you plan to address for each of the symptoms/behaviors described above?

28. Please describe the arrangements you have made in coordinating this treatment with the treatment being provided to the direct victim:

29. Is there any additional information that is important to be considered that is not addressed in this treatment plan? Please explain:

DECLARATION

CLIENT NAME: ______________________ CLAIM NUMBER: ______________________

If the victim's offender is convicted, the Board will request the criminal court to order the offender to pay restitution to reimburse the Board for any expenses the Board has paid for this crime. As a treating therapist you must be prepared to testify in a restitution hearing that the mental health counseling services you provided were necessary as a direct result of the crime at the percentage indicated below. **Please Note:** ***The Board can only pay for the percentage of treatment that is necessary as a direct result of the crime.***

A. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

- ☐ 0 %
- ☐ 25%
- ☐ 50%
- ☐ 75%
- ☐ 100%
- ☐ Other: __________%

B. What type of crime is the client being treated for?

- ☐ Assault With a Deadly Weapon
- ☐ Domestic Violence
- ☐ Child Abuse/Molest
- ☐ Sexual Assault
- ☐ Robbery
- ☐ Driving Under the Influence
- ☐ Hit and Run
- ☐ Homicide
- ☐ Other (Do not include any confidential facts in your description of the crime.) ______________________________

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by the Board or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under *Government Code section 12650* for filing a false claim with the State of California and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

I understand that mental health counseling treatment must be approved in advance. Treatment beyond the client's session limit will not be reimbursed until approved. I understand that if treatment is provided without the required approval, the Program may not reimburse those expenses.

IMPORTANT – You MUST Provide The Required Signature(s) Below

Treating Therapist:

Name: ____ Lic #: ____________________
(Please Print Clearly)

Signature: ____ Date: ____________________

Telephone Number: ________________________________

If Registered Intern:

Supervising Therapist's Name: ____________________________ Lic #: ____________________
(Please Print Clearly)

Signature: ____ Date: ____________________

Telephone Number: ________________________________

Tax Identification Number of person or organization in whose name payment is to be made:

____

If you would like to be contacted by email when possible, please enter your email address below (optional).

____