UTAH OFFICE FOR VICTIMS OF CRIME
Crime Victim Reparations Program

350 E 500 S Suite 200
Salt Lake City, Utah 84111

Mental Health Evaluation & Treatment Plan For Minors

TO BE COMPLETED BY THERAPIST

1. **Patient name** _____ **Birth date**_____
2. **Patient address** _____
3. **Indicate whether primary victim ( ) or secondary victim ( ) UOVC Claim No.** _____
4. **Describe the criminal incident that has affected THIS patient:**
    1. **General date of onset.**
    2. **Is the problem a direct result of this criminal incident? Specify in detail how this problem relates to the crime.**
    3. **Was the problem pre-existing but has been exacerbated by the crime? Specify in detail how the criminal incident has affected this problem.**
    4. **How has this patient's current level of functioning been affected by the crime?**
5. **Diagnostic Criteria for Direction of Treatment.**

ICD Code	**Disorder, Subtype and Specifiers**
__ __ __ . __ __	_____
__ __ __ . __ __	_____
__ __ __ . __ __	_____

State SPECIFICALLY and separately the patient's symptoms that support this diagnosis.

6. Please describe the anticipated treatment methods.

Recommended frequency and duration of treatment.

Treatment Method.

Select all that apply.

- ☐ Trauma-Focused Behavioral Therapy (TF-CBT)
- ☐ Parent-Child Interaction Therapy (PCIT)
- ☐ Dialectical Behavioral Therapy (DBT)
- ☐ Eye Movement Desensitization and Reprocessing (EMDR)
- ☐ Child and Family Traumatic Stress Intervention (CFTSI)
- ☐ Prolonged Exposure (PE)
- ☐ Attachment, Regulation, & Competency (ARC)
- ☐ Other:
- ☐ Other:
- ☐ Other:

If an "Other" treatment method was selected above, with SPECIFIC DETAIL, describe how treatment addresses the direct effect of the crime.

7. Describe SPECIFIC treatment goals for this patient. Include review dates in your description and method to monitor treatment response. Important to note, although not required, repeated use of a standardized, validated measure to monitor treatment response is strongly encouraged.

Select all that apply.

- ☐ UCLA PTSD Reaction Index
- ☐ Trauma Symptom Checklist for Children
- ☐ Trauma Symptom Checklist for Young Children
- ☐ Child PTSD Symptom Scale
- ☐ Youth Outcomes Questionnaire
- ☐ Other:

If "Other" method to monitor symptom change was selected above, please provide SPECIFIC DETAIL, how treatment response will be routinely monitored:

☐ **Treatment goals have been explained and reviewed with the patient/guardian.**

8. Please provide the following information for the therapist performing the treatment.

a. Full Name: _____

b. Credentials: _____

c. Agency: _____ **Street:** _____

City:_____ **State:**_____ **Zip:** _____ **Phone Number: ( )** _____

d. Describe any SPECIFIC training or knowledge in the treatment of victims and/or the treatment modalities listed above.

e Utah Professional License Number of Therapist Performing Treatment:_____

f. Federal Tax ID or Social Security Number of Provider:_____

NOTE: If therapist is "registered" with and/or has a temporary license but is not fully licensed with the State of Utah Department of Commerce Division of Professional & Occupational Licensing, the full name and signature of the licensed supervisor must be provided. Student interns are not eligible providers.

Signature of Therapist Performing Treatment: _____ **Date:**_____

Print Licensed Supervisor name (if necessary):_____

Signature of Licensed Supervisor (if necessary): _____ **Date:**_____

GUIDELINES FOR MENTAL HEALTH PROVIDERS
Effective March 26, 2015

The following guidelines apply to individuals awarded mental health benefits through the UOVC program.

1. **The victim's primary insurance or Medicaid must be billed prior to submitting claims to UOVC and all primary insurance guidelines must be followed. The therapist must be affiliated with the victim's primary insurance and include an Explanation of Benefits from the primary insurance carrier when submitting claims to UOVC.**
2. **Primary victims will be eligible for the lessor of 25 aggregate individual and/or group counseling sessions or $2,500 maximum mental health counseling award.**
3. **Secondary victims will be eligible for the lessor of 15 aggregate individual and/or group counseling sessions or $1,250 maximum mental health counseling award.**
4. **The cost of an evaluation will be limited to $300 and is considered part of the maximum mental health award.**
5. **UOVC claims are open for three years from the date of application.**
6. **Approval of this treatment plan does not constitute a contract with the State of Utah.**

Payment of mental health therapy shall only be considered when treatment is performed by a licensed mental health therapist based upon an approved Treatment Plan. The following maximum amounts shall be payable for mental health counseling:

- ☐ **up to $130 per hour for individual and group therapy performed by licensed psychiatrists and up to $65 per hour for group therapy;**
- ☐ **up to $90 per hour for individual and family therapy performed by licensed psychologists and up to $45 per hour for group therapy;**
- ☐ **up to $70 per hour for individual and family therapy performed by a licensed master's level therapist or Advanced Practice Registered Nurse and up to $35 per hour for group therapy.**

NOTE: These rates also apply to therapists working toward a license who are supervised by a licensed therapist. The rates apply to the individuals performing therapy and not those supervising treatment.