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| **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** |
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| 1. **Patient Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
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|  **2. Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  **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?**
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| **5. Diagnostic Criteria for Direction of Treatment:** |
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|  **ICD Code Disorder, Subtype and Specifiers** |
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|  **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. |
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| **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 family 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.**  |