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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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **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.** | | |