

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 Adults

TO BE COMPLETED BY THERAPIST

Preferred Name:				
Birth Date:				
victim () or secondary victim () UOVC Claim No				
1. Describe the criminal incident and how the client's functioning has changed as a result of the crime:				
of the crime, including approximate date of occurrence.				
s that have arisen as a direct result of the crime and impact on current level of functioning.				
mptom onset.				
4. Was the problem pre-existing but has been exacerbated by the crime? If yes, please specify in detail how the criminal incident has affected this problem.				
irection of Treatment:				
Disorder, Subtype and Specifiers				
and separately the patient's symptoms that support this diagnosis.				
and separately the patient's symptoms that support this diagnosis.				

6. Please describe the anticipated treatment methods.
Which specific interventions are included in your treatment plan for this client (select from below):
Strongly recommended treatments for crime victims: Select all that apply. Cognitive Processing Therapy Eye Movement Desensitization and Reprocessing (EMDR) Prolonged Exposure Therapy Trauma-focused Cognitive Behavioral Therapy (TFCBT) Narrative Exposure Therapy
Treatments with some evidence among crime victims: Brief Eclectic Psychotherapy Acceptance and Commitment Therapy with other therapies Interpersonal Therapy Present Centered Therapy Solution Focused Therapy Seeking Safety Other: Please indicate how this specific approach is better suited for the client than the above named evidence-based treatments:
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. (Examples: Beck Depression Inventory, PCL5, GAD7, etc.) • Treatment Goal(s)
Measurement Tool/Monitoring Approach
Review Date
☐ Treatment goals have been explained and reviewed with the patient/guardian.

a.	Full Name:		
b.			
c.			
	City:	State: Zip:	Phone Number: ()
d.	Describe any SPECIFIC training above.	g or knowledge in the treatment	t of victims and/or the treatment modalities listed
e			eatment:
f.	Federal Tax ID or Social Securit	y Number of Provider:	
Depart	ment of Commerce Division of Pro	ofessional & Occupational Lice	eet the licensing requirements of the State of Utah ensing are eligible providers. The full name and sionally licensed providers and student interns.
	nature of Therapist Performing Tre	atment:	Date:
Sign		essary).	
	nt Licensed Supervisor Name (if neo	.essai y):	

GUIDELINES FOR MENTAL HEALTH PROVIDERS Effective December 8, 2023

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.
- 3. Secondary victims will be eligible for the lessor of 15 aggregate individual and/or group counseling sessions.
- 4. UOVC claims are open for three years from the date of application.
- 5. 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 based upon an approved Treatment Plan. The maximum amounts payable for mental health services are based upon the rate established by Public Employees Health Plans (PEHP) Insurance.