



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

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 and how the client's functioning has changed as a result of the crime:

1. Brief description of the crime, including approximate date of occurrence.
2. List any symptoms that have arisen as a direct result of the crime and impact on current level of functioning.
3. General date of symptom 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.

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.

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: Licensed mental health professionals and student interns who meet the licensing requirements of the State of Utah Department of Commerce Division of Professional & Occupational Licensing are eligible providers. The full name and signature of the licensed supervisor must be provided for all eligible provisionally licensed providers and student interns.

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 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.