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 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?**
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: 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.