# 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.**

**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.**

**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: ( )** _____

**Email:** _____

**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.**