Victim Compensation Board
Department 5031
P.O. Box 20,000
Grand Junction, Colorado, 81502
Telephone: 970-244-1730
Fax: 970-256-1432
Email: victims.comp@mesacounty.us

21ST JUDICIAL DISTRICT
CRIME VICTIM COMPENSATION BOARD

MENTAL HEALTH THERAPY INITIAL TREATMENT PLAN FORM

Prior approval for crime related mental health treatment and/or submission of this form does not guarantee payment of additional mental health treatment services. You will be notified in writing of all Board decisions. All treatment costs exceeding the approved amount determined by the Board are the responsibility of the claimant. This form may be emailed to you for convenience.

CLIENT INFORMATION:

Name: _____ DOB:_____
Address: _____
City/State/Zip: _____
Client's Parent/Legal Guardian (if under 18): _____

THERAPIST INFORMATION:

Name: _____ License No._____
Business Address: _____
City/State/Zip: _____
Telephone Number: _____ Fax Number: _____
Email: _____
Supervisor Name:_____ License No._____

CLIENT TREATMENT INFORMATION:

Date Treatment Began: _____ Number of Sessions to Date: _____
Date of Crime: _____ Type of Crime: _____
Is the presenting issue related to the crime listed above? ◯ No ◯ Yes

Treatment Modalities to be Used:
☐ Individual ☐ Group ☐ Other:_____

1. Please describe the behavioral and emotional symptoms currently displayed by the victim:

2. Please list any pre-existing mental health issues exacerbated or discovered due to the crime against the victim:

3. List the treatment goals/objectives relative to the victimization (each goal should have an estimated completion date; please include safety planning and education as appropriate.):

Revised 3/2022