



Treatment Plan/Additional Treatment Plan Information Sheet

Please read the following information carefully prior to completing the Treatment Plan (TP) or Additional Treatment Plan (ATP). Failure to entirely complete the forms timely and legibly may result in denial of reimbursement or a repayment to the California Victim Compensation Program (CalVCP) for services previously reimbursed.

General Information:

In order for CalVCP to pay for services, the claimant's application must be found eligible. After eligibility has been determined, CalVCP may consider reimbursement for outpatient mental health counseling up to the claimant's session limit, as shown in Table A.

Statute requires that CalVCP verify that treatment is necessary as a direct result of the crime for which the application was filed. To verify appropriateness of reimbursement, additional information (i.e. session notes or a letter of explanation) may be requested.

Additionally, the requested additional information must be provided at no cost to the claimant, CalVCP, or local Victim/Witness Assistance Centers within ten (10) business days from the date of the request. Failure to complete the Treatment Plan and/or provide the requested additional information may result in denial of reimbursement or a repayment to CalVCP for services previously reimbursed. CalVCP certifies that there is a signed authorization on file for release of the information requested.

TABLE A
Mental Health Session Limitations
(For applications received on or after 01-24-06)

Session Limitation	Claimant/Patient Filing Status
40 Session Hours	Direct Victim – \$10,000 statutory limit Derivative Victim who is a surviving parent, sibling, child, spouse, registered domestic partner, or fiancé (fiancée) of a victim who becomes deceased due to the crime – \$10,000 statutory limit ^{2,3}
30 Session Hours	Direct Victim of Unlawful Sexual Intercourse (as defined by Penal Code, section 261.5(d)) – \$5,000 statutory limit ¹ Derivative Victim who was a minor at the time of the crime – \$5,000 statutory limit ¹ Derivative Victim who was one of two primary caretakers of a direct victim who was a minor at the time of the crime – \$10,000 statutory limit (to be shared with one other primary caretaker) Minor witness to violent crime (eff. 01-01-09) - \$5,000 statutory limit ² Good Samaritan (as defined by Government Code, section 13970) - \$10,000 statutory limit ³
15 Session Hours	Derivative Adult Victim – \$5,000 statutory limit ¹ Derivative Victim who does not meet any of the benefit limits listed above – \$5,000 statutory limit ¹ Post-Crime Caretakers (became primary caregiver of minor direct victim after the qualifying crime and did not have a previous filing status relationship to the direct victim) - \$5,000 statutory limit

1) Not to exceed the statutory \$3,000 outpatient mental health limit for applications received prior to 01-01-08

2) Must have witnessed the crime

3) Effective for applications received on or after 12-01-14

TABLE B

Session Counts (Individual/Family Therapy)

½ Session =	Less than 45 minutes
1 Session =	45 - 74 minutes
1 ½ Sessions =	75 - 104 minutes
2 Sessions =	105 - 120 minutes

Session Counts (Group Therapy)

½ Session =	60 minutes
1 Session =	120 minutes
1 ½ Sessions =	180 minutes
2 Sessions =	240 minutes

Submittal of the Completed Treatment Plan

The Treatment Plan may be kept in the claimant's file, but must be submitted to CalVCP in the following circumstances:

<ul style="list-style-type: none"> • There has been a three year delay in treatment from the date or disclosure of the qualifying crime. • There has been a break in mental health treatment of one year or longer. • Treatment beyond the claimant's third session is less than 100 percent related to the qualifying crime. • Upon submission of an Additional Treatment Plan. • A Restitution Hearing against the offender has been ordered. • The claimant is a post-crime caretaker. • Upon request of CalVCP.
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Submittal of the Completed Additional Treatment Plan

Should the claimant require treatment in excess of his or her authorized session limit, an Additional Treatment Plan (ATP) must be submitted with the TP and approved by CalVCP. The ATP should not be completed before the claimant is within eight (8) sessions from reaching his or her authorized session limit.

The ATP must be submitted within 90 days after the date a bill for sessions that exceed the authorized session limit is received by CalVCP. If the ATP and TP are not submitted within the 90 day timeframe, bills for all dates of service that exceed the authorized session limit will be returned and will not be considered for payment. However, bills for dates of service provided after the ATP and TP are received may be considered for payment, subject to approval of the ATP (California Code of Regulations, section 649.26(c)).

Please be advised that sessions provided to the claimant by another mental health provider are counted against the amount of sessions available under his or her initial session limit.

You may contact customer service for session count/limit verification (800-777-9229).



Additional Treatment Plan (Confidential)

Please submit this form if the claimant is within **eight (8)** sessions, or has reached the mental health benefit limitations and additional treatment is necessary as a direct result of the crime for which the California Victim Compensation Program (CalVCP) application was filed. If you are the continuing therapist, please include a copy of your initial Treatment Plan. CalVCP is unable to authorize and reimburse additional sessions until the Additional Treatment Plan is reviewed and approved. **CalVCP recommends that providers review the Treatment Plan/Additional Treatment Plan Information Sheet prior to filling out this form.**

Return this form to: CalVCP
 P.O. Box 942003
 Sacramento, CA 94204-2003

Application Number:	Date the Qualifying Crime Occurred:		
Claimant/Client Name:	Date Treatment Began:		
Direct Victim Name:	Most Recent Date of Treatment:		
Agency/Organization (if applicable):	Number of Sessions Provided:		
	Individual	Group	Family/Conjoint
Treating Therapist Name and Licensure:			
Email Address (required for notification):			
Telephone Number:			
1. Claimant's Relationship to Direct Victim: <input type="checkbox"/> Self <input type="checkbox"/> Other (please specify)_____			
2. Please describe the crime(s) for which you are providing treatment including relevant details provided to you.			
3. If the victimization occurred longer than three years ago or there was a break in treatment of one year or longer, describe the events, behaviors or reasons the claimant has sought treatment at this time.			

4. **If the claimant is a derivative victim** of a surviving direct victim, please list and describe the interventions for the claimant that are aimed at alleviating the direct victim's symptoms.

Direct Victim's Symptoms/Behaviors	Interventions for the Derivative Victim

5. Please indicate the DSM 5 code of the claimant's diagnosis and specifiers, and other conditions that may be the focus of clinical attention. If the criteria for a diagnosis are not present, please provide the Z-Code (i.e. V-Code in previous DSM versions).

Principal Diagnosis: _____ Additional Diagnoses: _____

6a. **If you are the continuing therapist**, please rate the status of the claimant's symptoms and resulting behaviors as shown on your Treatment Plan in relation to the completion of the listed treatment goals on a scale from 1 to 10, with 1 representing the lowest score and 10 the highest. If the symptoms/behaviors have remained the same or worsened, please provide a brief explanation on an attachment sheet.

Worsened	Remained the Same	Improved	Approaching Completion	Completed
1 2	3 4 5	6 7 8	9	10
Symptom/Behavior: _____			Rating Score: _____	
Symptom/Behavior: _____			Rating Score: _____	
Symptom/Behavior: _____			Rating Score: _____	
Symptom/Behavior: _____			Rating Score: _____	

Note: If there is a change of therapists within the same provider organization, the succeeding therapist is not considered a new therapist for this claimant and must assess the claimant's therapeutic progress since treatment began with the organization.

6b. **If you are a new therapist (or continuing therapist treating additional symptoms/behaviors)** please describe what symptoms/behaviors will be or have been the treatment focus and what you hope to achieve upon completion of treatment.

Symptom/Behavior: _____	Intervention: _____

7. Level 1 Cross-Cutting Symptom Measure (Please refer to pages 734-741 of the DSM 5.)

Adults			
Domain	Highest Score	Domain	Highest Score
I.		VII.	
II.		VIII.	
III.		IX.	
IV.		X.	
V.		XI.	
VI.		XII.	
		XIII.	

Children			
Domain	Highest Score	Domain	Highest Score
I.		VII.	
II.		VIII.	
III.		IX.	
IV.		X.	
V.		XI.	
VI.		XII.	

8. **FOR CONTINUING THERAPISTS ONLY** (over 15 sessions provided): Please rate this claimant's therapeutic progress with respect to the methodology and measurement/assessment tools that you identified in your previous treatment plan:

Please explain your ratings:

9a. **FOR ADULTS:** Please describe any factors you believe may adversely affect treatment progress. Consider factors such as inadequate housing, employment, physical health, transportation, child care and social network.

9b. **FOR CHILDREN:** Please describe any factors you believe may adversely affect treatment progress. Consider such factors as educational or developmental delays, living circumstances, inadequate caretakers and peer support network.

10. Do you expect the claimant to have further proceedings with the legal system in regards to the qualifying crime?

Yes No

If answer is yes, please explain:

11. Was the perpetrator of the crime released from custody?

Yes – If “yes” please provide the date the perpetrator was released from custody _____/_____
(Month) (Year)

No

N/A

12. Do you expect the claimant will be subject to uninvited or unwelcome contact with the alleged suspect that is not court authorized?

Yes No

If answer is yes, please explain:

13. Has the claimant terminated treatment (i.e. claimant not returning for treatment at this time)?

Yes No

Date of termination _____

DECLARATION PAGE

Application Number:

Claimant Name:

If the victim's offender is convicted, CalVCP will request the criminal court to order the offender to pay restitution to reimburse CalVCP for any expense CalVCP has paid for this crime. As a treating therapist you may be required to testify in a restitution hearing that the mental health counseling services you provided were necessary as a direct result of the crime at the percentage indicated below. Please Note: CalVCP can only pay for the percentage of treatment that is necessary as a direct result of the crime for which the application was filed.

In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

50% 75% 100% Other _____%

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by CalVCP or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above.

I understand that mental health counseling must be approved in advance, and that if treatment is provided without the required approval, CalVCP may not reimburse those expenses.

This document will not be reviewed without the required signature(s) and date(s) below.

Treating Therapist:

Name: _____ License No. _____

(Please Print Clearly)

Signature: _____ Date: _____

If Treating Therapist Requires Supervision:

Supervising Therapist's Name: _____ License No. _____

(Please Print Clearly)

Signature: _____ Date: _____

Privacy Notice on Collection

1. VCGCB collects this information based on California Government Code sections 13952 et seq. and 13954.
2. All information collected from this site is subject to, but not limited to, the Information Practices Act. See <http://vcgcb.ca.gov/media/prs.aspx>.
3. This information is collected for the purpose of determining eligibility for compensation.
4. VCGCB may disclose your personal information to another requestor, only if required to do so by law or in good faith that such action is necessary to:
 - a. Conform to the edicts of the law or comply with legal process served on VCGCB or the site;
 - b. Protect and defend the rights or property of VCGCB; and,
 - c. Act under exigent circumstances to protect the personal safety of users of VCGCB, or the public.
5. Individuals are to provide only the information requested.
6. The information provided is mandatory.
7. The consequences of not providing the requested information could result in the denial of your application.
8. You have the right to access the records containing the personal information that you provided.
9. The information collected is used by the California Victim Compensation Program.
10. Any questions regarding the information collected, please write to the following address: 400 R Street, 5th Floor Sacramento, CA 95811, email info@vcgcb.ca.gov, call (800) 777-9229, or contact the VCGCB Privacy Coordinator at InfoSecurityandPrivacy@vcgcb.ca.gov.
11. For additional information regarding privacy, please see VCGCB's Privacy Notice. See <http://vcgcb.ca.gov/privacy.aspx>.
12. For information regarding consumer information on security, please visit <https://oag.ca.gov/privacy/online-privacy>.