

## DENVER CRIME VICTIM COMPENSATION BOARD REIMBURSEMENT POLICIES

The Denver Crime Victim Compensation (CVC) Board has established the following guidelines for therapists requesting reimbursement for providing therapy. These guidelines apply in every case and any questions concerning these policies should be addressed to CVC staff at:

[victimcomp@denverda.org](mailto:victimcomp@denverda.org) or 720-913-9253

- The Board **requires** the use of the attached treatment plan.
- Incomplete or **handwritten treatment plans will not be accepted.**
- **Required signatures** include that of the client, the client's parent or guardian, the therapist, and the therapist's supervisor when the therapist is unlicensed. Unsigned treatment plans will be returned and payment will be delayed.
- **All of the questions in the treatment plan must be answered including the questions regarding insurance. Omitting a question or section of the treatment plan will result in the treatment plan being returned and payment will be delayed.**
- Payment for **three therapy sessions** is pre-approved by the Board and will be included as part of the total award.
- The Board determines who is eligible for therapy as a secondary victim. **Family members of a primary victim are not automatically eligible for assistance.**
- The Board will pay for **one, one hour session per week** unless other arrangements have been approved by the Board.
- The **treatment must be related to the specific crime** for which the client applied for CVC.
- Treatment plans and bills for services must be received **by the last day of the month in order for the Board to review them the following month.**
- The Board reimburses at a rate of **\$120** per individual session and **\$50** per group session.
- The Board does not pay for couples therapy, court-ordered therapy, or any sessions that include the perpetrator. The Board may ask for additional information if the client is younger than three years old.

**DENVER CRIME VICTIM COMPENSATION BOARD  
COUNSELING PLAN**

Please consider the following before completing the counseling plan.

- Has your client completed, signed and submitted an application for Crime Victim Compensation?
- If you determine that the client's needs are outside your field of expertise, are you prepared to refer the client?
- A separate treatment plan must be submitted for each person receiving treatment.
- Family members are not automatically eligible for assistance.
- Pre-approval of 3 initial sessions of therapy or submission of this form does not guarantee an award for continued therapy. Please make sure the insurance question is answered .
- An extension of therapy sessions in addition to the initial award is not guaranteed.

**Hand written treatment plans will not be accepted and will be returned without being reviewed by the Board.** (For your convenience, you may reconstruct this document on your computer or email [Victimcomp@denverda.org](mailto:Victimcomp@denverda.org) to request an electronic copy of this form.)

**Client information:**

Client: \_\_\_\_\_ CVC case #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Parent or Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Nature of crime: \_\_\_\_\_ Date of crime: \_\_\_\_\_

**Therapist information:**

Therapist name: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_  
Credentials: \_\_\_\_\_

License Number: \_\_\_\_\_  
If not licensed, **level and field of education:** \_\_\_\_\_

If not licensed, **Supervisor's information is required as follows:**

Supervisor's License Number: \_\_\_\_\_  
Supervisor's degree/level of education \_\_\_\_\_  
Hours per month of supervision provided \_\_\_\_\_  
Supervisor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Name of individual or agency to whom payment should be made.**

\_\_\_\_\_

**Handwritten treatment plans will be returned without being reviewed by the Board.**

**Treatment Planning:**

1. Behavioral and emotional symptoms displayed by the crime victim.
2. What are the *client's reasons* for seeking services?
3. Treatment goals related to the crime and specific to this client.
4. Are there pre-existing issues that will affect treatment?
5. The purpose of Crime Victim Compensation is to provide short-term trauma centered treatment. If the treatment needs of this client exceed the limits of the Crime Victim Compensation Program, **what is your plan to transition this client to other treatment?**

**Treatment modalities:**

1. Discuss the specific treatment modalities used to achieve the goals.
2. Describe any issues that may affect the length of treatment or its effectiveness.
3. What other recommendations or treatment referrals might be made (i.e. psychological assessment, group therapy, family therapy, psychiatric evaluation for medication, etc.)?

**Estimated length of treatment:**

Date client entered therapy: \_\_\_\_\_ # of sessions to date: \_\_\_\_\_  
Requested # of individual session: \_\_\_\_\_  
Requested # of family sessions: \_\_\_\_\_  
Requested # of group sessions: \_\_\_\_\_ Anticipate termination date: \_\_\_\_\_

**Insurance information:**

All bills must be submitted to the victim’s **insurance** company or other third party payer prior to being submitted to the Board. The Board will only approve that amount for which the victim is directly responsible.

**Does the client have mental health coverage included with insurances?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**Are you a provider for this insurance carrier?** Yes \_\_\_\_\_ No \_\_\_\_\_

**If so, have you billed insurance?** Yes \_\_\_\_\_ No \_\_\_\_\_

Insurance company name: \_\_\_\_\_

Insurance coverage: (deductible, percentage, mental health coverage)

Total amount requested: \_\_\_\_\_

**Signatures section**

**Claimant or parent/ guardian and therapist must sign this form**

Submission of the treatment plan **does not guarantee payment**. Victim Compensation does not pay **for missed appointments**.

The Crime Victim Compensation program only pays for treatment related to the crime. CVC **does not pay for court-ordered treatment or substance abuse treatment**. CVC does not pay for the therapist to accompany the client to court, or for consultation with employers, schools, Departments of Human Services or others. The Board does not pay for couples therapy or therapy that includes the perpetrator. The Board will only pay for therapy provided in a professional office and will not pay for therapy provided in the victim’s home.

**I hereby attest that the information contained herein is correct to the best of my knowledge and belief, and all treatment for which I am requesting payment through the Crime Victim Compensation Program is related to the criminal incident under which my client’s claim was approved.**

Therapist’s signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor’s signature, (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Client/parent or guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

For your information, some of our files and criminal justice records may be subpoenaed for court proceedings.

**Please return to:**

**Crime Victim Compensation  
370 Seventeenth St., Suite  
5300  
Denver, CO 80202**

[victimcomp@denverda.org](mailto:victimcomp@denverda.org)  
**720-913-9253 (phone)  
720-913-9035 (fax)**