Victims Compensation Program
60 South Main Street
Waterbury, Vermont 05676
802-241-1250 FAX 802-241-1253

Please copy for future use

MENTAL HEALTH TREATMENT PLAN

Provider Information

Name:_____
Address:_____
Telephone Number:_____ License/Certification Number:_____
Supervisor:_____ Supervisor License Number:_____
Are you a Medicaid provider? No_____ Yes_____ If yes, types:_____
Is the victim in DCF custody? No___ Yes_____

Client Information

Client Name:_____ Victim Name:_____

Does the client have insurance? No_____ Yes _____ Insurance Carrier Name: _____
Does the client have Medicaid? No_____Yes _____
Are you presently billing Medicaid for these services? No_____Yes _____
If you are not billing client's insurance, please explain _____

Type of crime: **sexual assault**_____ **domestic violence**_____**child sexual abuse** _____ **assault** _____
child physical abuse _____ **homicide** _____ **other (please list)**_____
Date of crime: _____
Suspect: _____
Status of criminal proceedings:_____

Treatment Information

Individual/Family Counseling _____ Group Counseling _____

Diagnosis: _____

Please briefly describe the client's symptoms related to the crime:

What are the goals of the treatment:
1.

2.

3.

Date of first session: _____
Based on the crime-related symptoms presented, what is the estimated number of sessions for this treatment? _____

Provider Agreement

I certify that the treatment being billed to the Victims Compensation Program for the above-named client focuses directly on the crime mentioned above, and is trauma/crisis oriented. I have read the Mental Health Policy and Payment Policy and agree to abide the by the conditions in these policies.

I understand that if I am receiving payment through any grant, contract, funding source, or if I am a salaried employee through another agency that is paying for my services, I cannot bill the Victims Compensation Program for the same services.

I also understand that the Victims Compensation Program is last payer, and acknowledge that I must bill the client's insurance first, unless otherwise agreed upon with the Victims Compensation Program.

I agree to inform the Victims Compensation Program immediately in writing when charges have been filed against me by the Office of Professional Regulation. I must also notify the Program if my license or roster becomes inactive, revoked, or conditioned in the state in which I practice.

_____

Provider Signature Date

(amended 6/15/99; 12/6/2010; 1/31/11;1/18/2016)