VERMONT

Vermont Center for Crime Victim Services
58 South Main Street, Suite 1
Waterbury, VT 05676-1599
www.ccvs.vermont.gov

[phone] 802-241-1250
[phone] 800-750-1213
[fax] 802-241-1253 (Victims Compensation only)
[fax] 802-241-4337 (General fax)

Sexual Assault Program
Mental Health Treatment Plan

Introduction: If, after receiving a sexual assault examination as defined by statute [V.S.A. 32 §1407(b)], the victim may choose to seek mental health counseling. The Sexual Assault Program can consider costs for mental health counseling not covered by the victim's health insurance. The victim's insurance must be billed first and any co-payment, coinsurance, and/or deductible amounts up to the Program's policy limits will be considered. The Sexual Assault Program can consider payment of up to 20 sessions of crime related mental health counseling. The victim is not required to report the sexual assault to law enforcement.

You may call the Sexual Assault Program Specialist at 802-241-1250 x104 with any questions.

Provider Information

Name: ____
Address: ____
Telephone number: ____
Email: ____
License/Certification Number: ________________________________

Client Information

Victim Name: ____
Date of Sexual Assault: ______________________________________
Does the victim have insurance? _____yes _______no
Insurance carrier name: ______________________________________
If you are not billing victim's insurance, please explain: ________________
____

Date of initial session: __________________

Treatment Information

(Please check one) ☐ Individual Counseling ☐ Group Counseling

Diagnosis: ____

Please briefly describe the client's symptoms related to the sexual assault:

What are the goals of the treatment?

1.

2.

3.

Provider Agreement

I certify that the treatment being billed to the Sexual Assault Program for the above-named client focuses directly on the crime of sexual assault and is trauma/crisis oriented. I have read the Sexual Assault Mental Health Policy and agree to abide by the conditions in this policy.

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

I agree to notify the Program if my license or roster becomes inactive, revoked, or conditioned in the state in which I practice. I also agree to inform the Sexual Assault Program immediately in writing if charges are ever filed against me by the Office of Professional Regulation.

Provider Signature: ___________________________________

Date: ____