Victims Compensation Program
58 South Main Street, Suite 1
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.

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Provider Signature Date

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