Submit this document to:
Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

CVCP INITIAL RESPONSE AND ASSESSMENT: FORM II

This form must be submitted by six sessions, if you are seeking authorization to provide more than six sessions. Preauthorization for payment of additional sessions, is contingent on the detail provided in this form. The CVCP application for benefits must also have been processed and approved.

Bill Procedure Code 0123C For This Report.

Victim's Name			CVCP Claim Number
Family Member's Name (if counseling is for a family member of a sexual assault or homicide victim)			Date Treatment Begun
Time Period this Report Covers (from month/day/year to month/day/year)			Date Form Completed
Clinician's Name	Clinician's Provider Number (if known)		Number of sessions to date
Clinician's Address			Clinician's Phone Number ( )
Street	City	State	ZIP+4

Does your patient have insurance other than CVCP? If so what insurance is available____________________________

It is your responsibility to verify your patient's insurance coverage and ensure its rules are being followed.

Please review the CVCP guidelines on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) What is the client's or caregiver's initial description of the crime incident for which they have filed a CVCP claim? If the victimization was not recent, please describe what brought the victim into treatment as this time.

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2) Briefly summarize the essential features of the victim's symptoms, related to the crime impact, beliefs/attributions, vulnerabilities, defenses and/or resources that led to your clinical impression (refer to the current DSM and CVCP guideline on Initial Response, Assessment and Documentation Procedures):

3) Please describe pre-existing or co-existing emotional/behavioral or health conditions relevant to the crime impact if present, and explain how they were exacerbated by the crime victimization (e.g. depression anxiety, vulnerabilities in personality structure, etc.).

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4) List diagnoses on all 5 Axes ***(be certain all diagnostic criteria are met).***

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V/Current GAF:
Highest GAF past year:

5) Treatment plan (based on diagnosis and related symptoms, see the CVCP guideline on Initial Response, Assessment and Documentation Procedures).

   A. What are the specific treatment goals that you and the victim have set? Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant other.

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B. What are the treatment strategies to achieve these goals? How many sessions are you requesting?

C. How will you measure progress toward these goals?

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D. Describe auxiliary care that will be incorporated (e.g. psychiatric evaluation, medication management, spiritual healers, community services, other services).

6) Please describe your assessment of the victim's treatment prognosis, as well as any extenuating circumstances and/or barriers that might affect treatment progress (e.g., previous trauma history, preexisting emotional/behavioral or medical conditions, family and social support system response and dynamics, religious/spiritual beliefs, cultural practices, involvement in criminal justice system or proceedings involvement with Child Protective Services, etc.).

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7) Has the victim been unable to work as result of this victimization?

☐ No
☐ Yes; please list the date(s) the person was unable to work and if applicable, give an estimated date of when the individual will return to work. Please explain why the victim is unable to work, the extent of impairment, and the prognosis for future occupational functioning.

Dates:
Explanation:

RESET