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

CVCP TERMINATION REPORT: FORM VI

This form must be submitted within 60 days of the client's last session and you are no longer conducting treatment. Include a complete description of the client's diagnosis at the time of termination. This information will assist the CVCP should the client submit a reopening application at a later date.

Bill Procedure Code 0127C 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) Date of last session: _____

2) Diagnosis at the time client stopped treatment:

Turn page to continue

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3) Reason for termination ***(check all that apply):***

- ☐ Current goals achieved
- ☐ Client choice to terminate treatment
- ☐ Therapist choice to terminate treatment
- ☐ Parent/guardian choice to terminate treatment
- ☐ Client relocated
- ☐ Client unavailable
- ☐ Client referred to other services
- ☐ Other _____

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