

**Crime Victim Services Division  
Crime Victims' Compensation Program**

**Mental Health Form**

Date: 01/31/09

Claim Number: VC0800011

Date of Crime: 1/14/09

**This is a sample form- responses from the provider are in blue**

**PATIENT INFORMATION**

2. Name: FN MI LN <b>Sabrina S Example</b>	3. Date of Birth: <b>09/15/1990</b>	4. Social Security Number: <b>XXX-XX-XXXX</b>
5. Parent/ Legal Guardian: <b>Melinda S Example (mother)</b>	6. Date of First Treatment: <b>08/31/07</b>	

**7. DSM-IV DIAGNOSES (Indicate both the diagnosis and corresponding code.)**

Axis I: <b>300.4 Dysthymia</b>
Axis II: <b>No Diagnoses</b>
Axis III: <b>No Physical disease</b>
Axis IV: <b>Murder of father at her home</b>
Axis V: <b>60</b>

**TREATMENT ISSUES**

**8. Presenting Problem and its Relationship to the Crime**

Describe, in detail, the problems for which the patient is seeking treatment including observable cognitive, behavioral and emotional symptoms displayed by the victim.  
*Note: You must inform CVCP if this is court ordered evaluation or treatment.*

**Counseling is not court ordered.**

**Almost eight months ago, client was witness to her father being shot and killed by their next-door neighbor. The suspect (neighbor) walked over to the client's home and saw client's father grilling in the garage, and opened fire with a shotgun. Client heard the gunfire and ran to the garage and saw her father dying. The gunman still had the gun in hand and was walking back and forth, but did not fire any more shots.**

**Client presents with a great deal of anger, rage, sadness and grief. She has fears for the future (still living in the same neighborhood), and nightmares almost every night.**

**Client has had to pick up some of the household chores, since her mother has started a new job at hardware store. Her grades at school have slipped some and she finds it difficult to study.**

**9. History**

Does the patient have a history of previous mental health treatment?

Yes

No

If so, indicate the dates of treatment, reason(s) for the treatment, the types of treatment and the name of the provider in the box below.

Are there any pre-existing mental health issues affected (exacerbated) or disclosed by the crime? If so, describe below.

Yes

No

Was there prior victimization or psychological trauma? If so, describe below.

Yes

No

Client saw a therapist (doesn't remember name) in Houston when her parents were considering a divorce 2 yrs ago.

Example

**10. Describe the patient's current level of functioning, noting areas of impairment.**

**Social:** Client has continued to stay active through her school and church. She also has a boyfriend who has been at her side through out this period of time. She has been on a soccer team, but elected to quit for awhile.

**Psychological:** She is having nightmares and rage about the loss of her father. She appears depressed but is also grieving the loss of her father. She and her mother go to the grave site once every week.

**Family:** Remains very connected to her sisters and her mother. She does worry about her mother who appears to also struggle with the loss of her husband.

**Vocational:** Is attending high school and is in the 11<sup>th</sup> grade. Her grades have slipped, but she has plans for college and is working to bring up her GPA.

**Economic:** Is not employed.

### 11. TREATMENT PLAN

Describe the short-term treatment goals (less than three months).

- 1.) Start to verbalize the impact of her loss
- 2.) Increase her social network
- 3.) Start a journal to help her work through her grief
- 4.) Learn to cope with the feeling of "fear of the future" without her father

Describe the long-term treatment goals (longer than three months).

- 1.) Help her understand the impact of the loss of her father
- 2.) Assist client in re-directing her anger
- 3.) Improve her grades at school
- 4.) Improve her self image by starting an exercise (dance) regimen

Example

What is the prognosis?

Good if she remains in treatment, and if her mother will also start treatment.

Anticipated Termination Date (must enter date): 7/2009

### 12. DISABILITY

Is the patient unable to work due to the mental health condition related to the crime? If so, describe the nature and anticipated length of the disability below.

Yes

No

N/A

Still in high school and is not working. She is planning on a summer job at her church's daycare.

### 13. INSURANCE

Does the patient have a health care plan?

Yes  No

Is the patient currently on Medicaid or any other public insurance plan? (CVC does not need this form if Medicaid is payer).

Yes  No

Medicaid Provider Number \_\_\_\_\_

Yes  No

If "Yes" to either of the above, have you filed a claim with the insurer? On what date? \_\_\_\_\_ (Ins explanation of benefits must accompany bill.

Date \_\_\_\_\_

If the patient has a health care plan, complete the following:

Name of Carrier: <b>None</b> <b>Mother started hardware store, but is not eligible for insurance yet.</b>	Carrier Address:
Policy Number:	Group Number:

Example

14. Is the patient/client receiving counseling under a grant, free counseling, or reduced fee reimbursement (such as a sliding scale). If so, explain:

No

15. PROVIDER INFORMATION

Name: <b>Jane Doe LPC</b>		Name of Agency: <b>Shady Grove Counseling Services</b>	
Address, City, State, Zip Code: <b>1234 Elm XXXXX TX XXXXX-XXXX</b>		Telephone Number: <b>(512) 333-xxxx</b> Fax Number: <b>(512) 333-xxxx</b>	
License Number: <b>12345</b>	Discipline/Title: <b>LPC</b>	Supervisor: <b>none</b>	
Expiration Date: <b>01/2010</b>			

Signature Jane Doe Date 01/31/09

FOR OAG-CVCP OFFICE USE

<b>Client Name:</b>	<b>Client SSN:</b>	<b>VC</b> _____
<b>Date Received:</b>	<b>Reviewer:</b>	<b>Review Date:</b>
<b>Disposition:</b> <input type="checkbox"/> <b>Approved</b> <input type="checkbox"/> <b>Denied</b> <input type="checkbox"/> <b>Further Info</b> <b>Needed</b>		
<b>Provider Notified(date):</b>	<b>Approved to (date):</b>	<b>Additional Information Requested (date):</b>

Revised 03/08/04

Example