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 I

This form must be submitted if you are seeing the victim for six sessions or less. If you will provide more than six sessions, please complete Form II. Payment is contingent on the detail provided in this form and upon the processing and approval of the CVCP application for benefits.

Bill Procedure Code 0122C 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 victim'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) What are the victims's presenting symptoms/issue (by your observation and client report)?

3) Has the victim been unable to work as a 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:

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4) What type of intervention(s) did you provide?