

**Submit this document to:**  
**VCCB**  
**Department of Administration**  
**PO Box 110230**  
**Juneau, Alaska 99811-0230**  
**Facsimile – 907-465-3040**

**STATE OF ALASKA**

**VCCB INITIAL RESPONSE AND ASSESSMENT: FORM I**

Please submit this form if you are seeing the victim for six sessions or less. If more than six sessions are indicated, please complete **Form II**. Payment for treatment provided is dependent upon the processing and approval of the VCCB application for compensation.

Victim's Name

VCCB Claim Number

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Client's Name (if different then the victim's)

Date treatment began

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Clinician's Name and Provider Number

Number of sessions to date

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Clinician's Address

Clinician's Phone Number

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**Please review the VCCB guideline 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 VCCB claim? If the victimization was not recent, please describe what brought the victim into treatment at this time. If the crime occurred more than two years prior to the date of the VCCB application, justification for the Board's consideration of waiving the two-year time limit imposed by statute must be included.

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2) What are the victim's presenting symptoms/issues (by your observation and client report)?

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3) Has the victim experienced time loss from work as a direct result of the victimization?

\_\_\_ No

\_\_\_ Yes; Please list the date(s) the person was not able to work and if applicable give an estimated date when the individual should be able to return to work. Please explain why the time loss has occurred, the extent of the impairment and the prognosis for future occupational functioning.

Dates: \_\_\_\_\_

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Explanation: \_\_\_\_\_

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**VCCB INITIAL RESPONSE AND ASSESSMENT: FORM II**

Please submit this form if you more than six sessions are indicated for successful treatment. If six sessions or less are indicated, please complete **Form I**. Payment for treatment provided is dependent upon the processing and approval of the VCCB application for compensation.

Victim's Name

VCCB Claim Number

\_\_\_\_\_

\_\_\_\_\_

Client's Name (if different then the victim's)

Date treatment began

\_\_\_\_\_

\_\_\_\_\_

Clinician's Name and Provider Number

Number of sessions to date

\_\_\_\_\_

\_\_\_\_\_

Clinician's Address

Clinician's Phone Number

\_\_\_\_\_

\_\_\_\_\_

**Please review the VCCB guideline 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 VCCB claim? If the victimization was not recent, please describe what brought the victim into treatment at this time. If the crime occurred more than two years prior to the date of the VCCB application, justification for the Board's consideration of waiving the two-year time limit imposed by statute must be included.

\_\_\_\_\_









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VCCB PROGRESS NOTE: FORM III

This form should be completed after session 15. This form should serve as a reminder that you are more than halfway through the awarded number of 26 sessions. It is now time to consider whether or not the victim will need more treatment and the rationale behind it. **Form IV** must be completed and submitted at this time if additional sessions will be requested. In addition, the victim will need to submit a written request for reconsideration. Approval is not automatic and will only be granted under extraordinary circumstances.

Victim's Name

VCCB Claim Number

\_\_\_\_\_

\_\_\_\_\_

Client's Name (if different then the victim's)

Date treatment began

\_\_\_\_\_

\_\_\_\_\_

Clinician's Name and Provider Number

Number of sessions to date

\_\_\_\_\_

\_\_\_\_\_

Clinician's Address

Clinician's Phone Number

\_\_\_\_\_

\_\_\_\_\_

**Please review the VCCB guideline 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) Is there substantial progress toward recovery from the crime related condition(s)?

\_\_\_\_\_ Yes (continue on to question #2)

\_\_\_\_\_ No (continue on to question #3)



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**VCCB TREATMENT REPORT: FORM IV**

Please use this form if you are seeking approval for treatment beyond the awarded 26 sessions. Please note an additional award will only be made in extraordinary circumstances and requires a request from the claimant.

Victim's Name

\_\_\_\_\_

VCCB Claim Number

\_\_\_\_\_

Client's Name (if different then the victim's)

\_\_\_\_\_

Date treatment began

\_\_\_\_\_

Clinician's Name and Provider Number

\_\_\_\_\_

Number of sessions to date

\_\_\_\_\_

Clinician's Address

\_\_\_\_\_

Clinician's Phone Number

\_\_\_\_\_

**Please review the VCCB guideline 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 were the diagnoses at treatment onset?

Axis I:

\_\_\_\_\_

Axis II:

\_\_\_\_\_

Axis III:

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Axis IV:

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Axis V/Current GAF:

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Highest GAF past year:

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- 2) What are the current diagnoses (if different than those listed above)?

Axis I:

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Axis II:

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Axis III:

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Axis IV:

---

Axis V/Current GAF:

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Highest GAF past year:

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- 3) Request for additional sessions (**Complete both sections in either A, B, or C, whichever is applicable**)

- A. Substantial progress toward treatment goals has been made.  
Explain:

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VCCB TERMINATION REPORT: FORM V

This form is to be used if you are no longer conducting treatment.

Victim's Name

VCCB Claim Number

\_\_\_\_\_

\_\_\_\_\_

Client's Name (if different then the victim's)

Date treatment began

\_\_\_\_\_

\_\_\_\_\_

Clinician's Name and Provider Number

Number of sessions to date

\_\_\_\_\_

\_\_\_\_\_

Clinician's Address

Clinician's Phone Number

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please review the VCCB guideline 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 the client stopped treatment:

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\_\_\_\_\_  
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\_\_\_\_\_  
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