

Mental Health Provider Residential Security Verification Form

▶ **MUST** be completed by the Mental Health Provider

This form is for the treating mental health therapist to document when a victim of the qualifying crime is requesting residential security benefits from the California Victim Compensation Program (CalVCP) due to qualifying crime-related emotional trauma. This form is to help mental health providers document how the crime affected the victim's emotional well-being. The form may be used with or without a letter from the mental health provider. If a letter is submitted without this form, it must be on the provider's letterhead and contain all the information requested in this form including signature and license number.

Victim Information			
Name		Phone Number	
Address	City	State	Zip
Crime Information			
Crime Date		Type of Crime	
Mental Health Information			
Provider/Organization Name & Address:		License Number/ Expiration Date	
Is the victim currently receiving therapy for this qualifying crime? <input type="checkbox"/> Yes <input type="checkbox"/> No If <u>No</u> , on what basis are you making your assessment of the victim's need to install some type of residential security due to <u>emotional trauma</u> ?			
▶ Is it necessary for the victim to install some type of residential security due to emotional reasons directly related to the qualifying crime? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not enough information to determine			
▶ Explain why residential security is necessary for the victim's <u>emotional well-being</u> :			
▶ Describe the consequences if he or she does not install some type of residential security:			
<i>Important Note!</i> Psychology Intern, Marriage Family Therapist Intern, Psychological Assistant, Associate Social Worker, Sexual Assault or Domestic Violence Peer Counselor requires a signature from the <u>licensed supervising therapist</u> .			
Mental Health Provider Name:		Phone Number	
Signature	License Number	Date	
Licensed Supervising Therapist Name:		Phone Number	
Signature	License Number	Date	