Victim Compensation Board
Department 5031
P.O. Box 20,000
Grand Junction, Colorado, 81502

Telephone: 970-244-1737
Fax: 970-256-1549

21ST JUDICIAL DISTRICT
CRIME VICTIM COMPENSATION BOARD

MENTAL HEALTH THERAPY EXTENSION REQUEST FORM

This form is to be used only after the sessions approved under the initial assessment and treatment plan near termination. All Therapy Extension Requests must be returned to the Crime Victim Compensation program **30 days PRIOR** to the initial projected termination date.

Prior approval for crime related mental health treatment and/or submission of this form does not guarantee payment of additional mental health treatment services. You will be notified in writing of all Board decisions. All treatment costs exceeding the approved amount determined by the Board are the responsibility of the claimant. This form may be emailed to you for convenience. Hand written forms will not be processed and will be returned.

CLIENT INFORMATION:

Name: _____ DOB:_____
Address: _____
City/State/Zip: _____
Client's Parent/Legal Guardian (if under 18): _____

THERAPIST INFORMATION:

Name: _____ License No._____
Business Address: _____
City/State/Zip: _____
Telephone Number: _____ Fax Number: _____
Email: _____
Supervisor Name:_____ License No._____

CLIENT TREATMENT INFORMATION:

Date Treatment Began: _____ Number of Sessions to Date: _____
Date of Crime: _____ Type of Crime: _____
Is the presenting issue related to the crime listed above? ____ No ____ Yes

Treatment Modalities to be Used:
____ Individual ____Group ____ Other:_____

1. Describe the progress related to the initial treatment plan's goals/objectives (use objectives from initial treatment plan):

   a.

   b.

   c.

   d.

   e.

2. Please describe the behavioral and emotional symptoms currently displayed by the victim:

3. Please list any new or changes to treatment goals/objectives:

4. How do the changes in the treatment plan relate to the crime?

5. Number of additional sessions requested: _____

6. Frequency of therapeutic contacts: _____

7. New date of discharge with this patient: _____

CLIENT INSURANCE INFORMATION:

Has the Victim's insurance status changed since the initial treatment plan? ____ No ____ Yes

If 'Yes', how? _____

If 'No', why? _____

Company Name:_____

Policy Number: _____ Group Number: _____

I understand that Crime Victim Compensation is, by state law, the payor of last resort, and I further agree to apply for any primary insurance benefits of my client, if eligible. I understand that Crime Victim Compensation can only pay for the client's out of pocket amount as indicated by insurance. I further agree to only bill Crime Victim Compensation for sessions that are part of the above submitted treatment plan. I agree not to bill Crime Victim Compensation for treatment outside of the above treatment plan.

The information contained herein is correct to the best of my knowledge, information and belief. I understand and agree to the following:
I am a licensed therapist, or under the supervision of, who has experience working with trauma victims.

I will accept the **Board's** hourly reimbursement of **$80** for individual therapy and **$35** for group therapy as payment in full; and, I will request any necessary extension 30 days prior to the termination date of any award made.

I swear and affirm under the penalty of perjury that the statements herein are true and correct to the best of my knowledge and belief.

_____ _____
Therapist Signature Date

_____ _____
Therapist Supervisor Signature Date

_____ _____
Client/Guardian Signature Date

Once the Board has made an approval you will be notified in writing. The Board processes and issues payments only once a month, therefore payment could take up to 30 days after receiving an itemized bill/invoice.