20th JUDICIAL DISTRICT CRIME VICTIM COMPENSATION

Office of the District Attorney – 20th Judicial District
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www.bouldercounty.org/da

EXTENSION REQUEST FOR MENTAL HEALTH THERAPY

(All treatment forms *must* be typed. Illegible or incomplete forms may delay processing time. Please keep this template for future use or forms can be printed from our website: www.bouldercounty.org/da Also, Mental Health Providers should keep a copy of their client's completed form on file.)

This form must be submitted to request therapy above the initial sessions that were authorized. A *separate and complete* report must be submitted for each family member in treatment. Please submit this request prior to the conclusion of the initial authorization (at least one month prior.) The approval of the initial therapy sessions or the submission of this form does not guarantee payment for extended treatment. Do not submit a bill for sessions beyond the initial authorization until you are notified that an extension has been awarded. *Any and ALL treatment costs, which exceed the approved amount determined by the Board, are the responsibility of the claimant.*

Therapist Information Section:

Name of Therapist: _____ License # _____
Address: _____ Telephone: _____

Client Information Section:

Victim Compensation Claim # _____
Victim's Name: _____Victim's DOB: _____

Treatment Plan Section:

Date treatment began: _____
Number of sessions to date: Individual _____ Family _____ Group_____

Identification of current symptoms and changes in previously documented symptoms (relationship to crime):

Diagnosis (DSM-IV-TR): _____

Present treatment goals and relationship to criminal incident:

Evaluation of progress toward treatment goals:

Therapy methods related to updated goals:

Reasons for additional treatment request:

Estimated Length of Treatment Section:

Below, please provide an estimate of the number of sessions requested:

1. Individual sessions: _____
2. Group sessions: _____
3. Family sessions (must include primary victim): _____
4. Court Support Sessions (Primary victim only):
5. Frequency of therapeutic contacts: _____

Insurance Information Section:

Victim Compensation is the payer of last resort, as such, all health insurance coverage, including Medicaid and Medicare, must be utilized prior to the victim compensation program making awards.

Are you a provider for your client's insurance? ☐ Yes ☐ No
Company: _____Telephone Number: _____
Type of Mental Health Coverage: _____
Number of Sessions Allowed: _____ Deductible Amount: _____
Policy Number: _____

(***You may only bill for your client's out of pocket amount as indicated by insurance. Please include a copy of the Explanation of Benefits (EOB) with invoices that have been billed to insurance. If insurance is available but not going to cover services, a letter of denial to the Compensation Program must be provided.)***

Signature of Claimant and Therapist Section:

I, understand, swear, and affirm under penalty of perjury the following statements are true and correct to the best of my knowledge and belief:

- **The Treatment plan submitted and subsequent treatment billed to Crime Victim Compensation is directly related to the crime in which the claim was approved.**
- **The Crime Victim Compensation Board will not be billed for missed/cancelled appointments, court ordered treatment, trial attendance, report writing, couples counseling, professional consultations or any session not directly related to the crime in which the claim has been approved.**
- **Crime Victim Compensation is, by state law, the payer of last resort.**
- **I will apply for any primary insurance benefits if applicable.**
- **I shall reimburse the fund up to the total amount of compensation benefits paid which in fact were covered by other means.**

_____ _____

Therapist Signature Date

_____ _____

Supervisor's Signature (Required if treating therapist is unlicensed) Date

_____ _____

*Claimant's Signature: Date

**If client is under age of 18, parent or guardian must sign.