20th JUDICIAL DISTRICT CRIME VICTIM COMPENSATION
Office of the District Attorney; 1035 Kimbark St., Longmont, CO 80501
Phone: 720.564.2835 Fax: 303-416.8721
victimcomp@bouldercounty.gov
Additional forms can be obtained at www.bouldercounty.org/da

EXTENSION REQUEST FOR MENTAL HEALTH THERAPY

All treatment forms ***MUST*** be typed. Handwritten forms and forms without required signatures will be returned.
All treatment plans **MUST** be signed by the therapist (supervisor if applicable) and victim/claimant-guardian.
Attach additional information to this form if necessary.

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. *All treatment costs, which exceed the approved amount determined by the Board, are the responsibility of the claimant.*

Client Information Section:
Victim Compensation Claim # _____

Victim's Name: _____

Victim's DOB: _____

Therapist Information Section:
Name of Therapist: _____

License # _____

Address: _____

Email: _____

Telephone: _____

Treatment Plan Section:

Date treatment began: _____

Number of sessions to date: _____

Individual _____ Family _____ Group_____

The completion of this form does not constitute approval of this claim past the initial sessions that were approved by the Board. If additional sessions are authorized, you will be notified of the amount that the Board has set aside for future sessions. Any unused portion of the authorization will revert to the fund one year after approval of the authorization. In addition, if you are submitting this treatment plan prior to the Board's approval of your client's application, the completion of this form does not guarantee approval of funds.

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

Diagnosis (DSM-IV-TR): _____

1. Present ongoing treatment goals and relationship to criminal incident:

2. Evaluation of progress toward treatment goals:

3. Therapy methods related to updated goals:

4. Reasons for additional treatment request:

<u>Estimated Length of Treatment Section</u>:

Below, please provide an estimated number of additional sessions requested:

1. Individual sessions: _____
2. Group sessions: _____
3. Family sessions (must include primary victim): _____
4. 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.)

<u>Signature of Claimant and Therapist Section</u>:

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, court 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.**
- **The claimant is responsible for any sessions/charges not compensable through Victim Compensation.**

_____ _____

Date *****Therapist's signature ***(required)***

_____ _____

Date Supervisor's signature **(if applicable)**

_____ _____

Date *****Client's/Guardian's signature ***(required)***