



20th JUDICIAL DISTRICT CRIME VICTIM COMPENSATION

Office of the District Attorney – 20th Judicial District

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EXTENSION REQUEST FOR MENTAL HEALTH THERAPY

All treatment forms **MUST** be typed.

All treatment plans **MUST** be signed by the therapist, supervisor if applicable and victim.)

Handwritten forms and forms without required signatures will be returned.

Attach additional information to this form if necessary.

Please keep this template for future use.

This form must be submitted to request therapy beyond the sessions that were previously authorized. A **separate and complete** report must be submitted for each family member in treatment. Please submit this request prior to current authorizations being exhausted. Do not submit invoices 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 Crime Victim Compensation (CVC) Board, are the responsibility of the claimant.**

Therapist Information Section:

Name of Therapist: _____

License # _____

Address: _____

Telephone: _____

Email: _____

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. 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 must be provided.)

Signature of Therapist/Supervisor/Client 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:

- Therapist (supervisor if applicable) and client have reviewed this Extension Request and agree with it along with estimated number of sessions and treatment cost.
- The Extension Request submitted and 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, sessions that include the offender or any session not directly related to the crime for 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.

Therapist Signature (required)

Date

Supervisor's Signature (required if treating therapist is unlicensed.)

Date

Client/Guardian Signature (if client is under 18, parent/guardian must sign.)

Date