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**CRIME VICTIM COMPENSATION BOARD**

**EIGHTEENTH JUDICIAL DISTRICT**

**6450 S. REVERE PKWY**

**CENTENNIAL, COLORADO 80111**

**(720) 874-8787**

**VictimComp@da18.state.co.us**

**REQUEST TO EXTEND THERAPY/RESUME TREATMENT**

**HANDWRITTEN FORMS WILL NOT BE ACCEPTED**

Approval of initial therapy or submission of this form **does not guarantee payment** of extended treatment. Any and all treatment costs that exceed the Board award shall be the responsibility of the claimant. The client will be notified by letter of all Board decisions.

**DATE :** Click here to enter text.

**CLIENT INFORMATION:**

Name: Click here to enter text. Parent/Guardian: Click here to enter text.

Address: Click here to enter text.

 Click here to enter text.

Telephone No: Click here to enter text.

Current living situation: Click here to enter text.

**THERAPIST INFORMATION:**

Name: Click here to enter text. Supervisor:Click here to enter text.

Agency: Click here to enter text. Agency: Click here to enter text.

Address: Click here to enter text. Address: Click here to enter text.

 Click here to enter text. Click here to enter text.

Telephone No: Click here to enter text. Telephone No: Click here to enter text.

License No & Type: Click here to enter text. Supervisor License No & Type: Click here to enter text.

**UPDATED INSURANCE INFORMATION (ONLY if there has been a change of insurance/coverage):**

Company: Click here to enter text. Policy No: Click here to enter text.

Telephone No: Click here to enter text.

Type of Mental Health Coverage: Click here to enter text.

(Prior to any payment, a copy of coverage specific to benefits available, denied, deductible, co-pay or percentage insurance will pay per visit, per calendar year **must be returned**.)

**TREATMENT:**

Describe the client’s current symptomology that is directly related to his/her victimization.

Click here to enter text.

Describe the client’s progress in treatment **AND** the reason for the therapy extension request or request to resume therapy.

Click here to enter text.

List and describe any changes made to the original treatment goals that are directly related to his/her victimization.

Click here to enter text.

If so desired, please include any additional information that would assist the Victim Compensation Board when considering this request.

Click here to enter text.

**Please complete the section below:**

**\*\*PLEASE NOTE:**

**The Board will consider no more than 25 sessions for primary victim new claims on/after September 1, 2023 (20 sessions for claims prior to September 1, 2023).**

**The Board will consider no more than 10 sessions for secondary victim new claims on/after September 1, 2023.**

**Reimbursement rates listed are only applicable to treatment sessions on/after September 1, 2023.**

Choose an item. # additional **individual / family therapy** sessions requested at $120

 per session.

Choose an item. **#** additional **group** sessions requested at $50 per session.

Choose an item. # additional **INTERN** **individual / family therapy** sessions requested

 at $60 per session.

Frequency of sessions –

[ ]  1x a week

[ ]  Other – please explain Click here to enter text.

$ Click here to enter text.**TOTAL ANTICIPATED COST OF EXTENDED TREATMENT**

Both the claimant and the therapist must sign this form.

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Claimant Signature Date Therapist Signature Date

Please return completed forms to:

Victim Compensation Board

6450 S. REVERE PKWY

Centennial, CO. 80111

Fax: 720-733-4697

VictimComp@da18.state.co.us