Crime Victim Compensation

First Judicial District
500 Jefferson County Parkway, Golden, CO 80401
Phone: 303.271.6846 Fax: 303.271.6785
Email: da-cvc@jeffco.us

Mental Health Extension Request

Important:

1) This form **MUST BE TYPEWRITTEN**
2) Award for previous sessions does not guarantee approval of additional sessions.
3) Any treatment costs exceeding the approved amount determined by the Board is the responsibility of the client.
4) The client and mental health provider will be notified of the Board decision within 10 days after the Board meeting.
5) Incomplete and handwritten forms (including required signatures) will be returned without being reviewed.

Therapist Information:

Name: Click to enter text	Agency (if applicable): Click to enter text		License Number: Click to enter text	
Address: Click to enter text	City: Click to enter text	State: Click to enter text	Zip: Click to enter text	Phone: Click to enter text
Email Address: Click to enter text	Do you accept the claimant's insurance? ☐Yes ☐No			
Supervisor: (if applicable) Click to enter text	Supervisor's email address: Click to enter text			

Client Information:

Name: Click to enter text	CVC Claim number: Click to enter text	Date of Birth: Click to enter text	Relationship to Primary Victim: Click to enter text
Address: Click to enter text	City: Click to enter text	State: Enter State	Zip: Enter Zip
Phone: Click to enter text	Current living Situation: (i.e. with defendant, foster home, etc.) Click to enter text		
Parent/Guardian name/s: Click to enter text	Insurance Company and coverage information (i.e. deductible, number of sessions covered, etc.) Click to enter text		

Crime Information:

Defendant's Name: (if known) Click to enter text	Relationship to the victim: Click to enter text
What contact does the perpetrator currently have with the victim? Click to enter text	

Treatment Planning Section:

1. What symptoms, directly related to the victimization, is the victim/client currently displaying? (physical, psychological, emotional, and behavioral?)

Click to enter text

2. Describe progress (accomplishments of original goals) related to initial mental health treatment plan:

Click to enter text

3. Reasons for additional treatment:

Click to enter text

4. Please describe any changes, in treatment plan or approach, that will be taken to meet treatment goals.

Click to enter text

5. List the treatment modalities used to achieve these goals.

Click to enter text

6. Please mark if therapy sessions will be in person (only): ☐ teletherapy (only): ☐
   or a combination of both in person and teletherapy sessions: ☐
   ** If Teletherapy sessions are checked, please list the HIPPA approved virtual platform being used (per guidelines in the CVC MH packet) Click or tap here to enter text.

7. CVC funds are limited, and only available to help the victim initiate the recovery from the trauma of the crime. What plan have you made with this client if treatment needs exceed the limited number of extension sessions requested?

Click to enter text

Additional sessions requested:

Note: Primary victims, and secondary victims of homicide or death related cases, may be eligible for an extension of therapy through this program.

*The CVC Board will only consider **15** (total) additional sessions per extension request.*

All sessions should be used within 1 year of award

Number of sessions held to date: Choose an item.

Number of additional sessions you would like the CVC Board to consider:

Choose a number from drop down - Individual Sessions – primary victims and secondary victims on homicide cases only. **(Sessions must be a minimum of 45 minutes in duration to be CVC compensable)**

***New fee structure is effective for sessions beginning 5/1/2023: $100/session for unlicensed provider with supervision of licensed provider, $130/session for licensed provider (see list in MH packet), and $150/session for licensed psychologist.**

**** EMDR, Micro-current Neurofeedback (MCNF), Neurofeedback (NF), etc. sessions should be included in the total number of individual sessions selected above.**

Signature Section:

I understand, swear, and affirm that 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 CVC is directly related to the crime in which the claim has been approved.

- The CVC Board will not be billed for missed/cancelled appointments, trial attendance, report writing, couples counseling, or any session not directly related to the crime in which the claim has been approved.
- Crime Victim Compensation is, by law, the payor of last resort. If insurance is available, invoices must be submitted to the insurance company first.
    - Please include a copy of the Explanation of Benefits (EOB) for each session along with invoices that have been billed to insurance.
    - If insurance is available but is not going to cover services, a letter of denial or explanation of coverage limitations must be provided.

Click to enter name		
Victim/Guardian Printed Name	Victim/Guardian Signature	Date
Click to enter name		
Mental Health Provider Printed Name	Mental Health Provider Signature	Date

Please submit this treatment plan with signatures (required) to:

Email: da-cvc@jeffco.us

Fax: 303.271.6785

Mail: First Judicial District Attorney
Attn: Crime Victim Compensation Board
500 Jefferson County Parkway
Golden, CO 80401

*Updated 5/1/2023