First Judicial District (Jefferson and Gilpin Counties)

THERAPIST QUESTIONNAIRE

* **WE DO NOT ACCEPT HANDWRITTEN FORMS**

# Name: Click or tap here to enter text.

**Business Address:** Click or tap here to enter text.

**Check should be made payable to (name of person or agency):** Click or tap here to enter text.

**Mailing Address (where payments will be mailed):** Click or tap here to enter text.

**Phone:** Click or tap here to enter text.

**Fax:** Click or tap here to enter text.

**E-mail:** Click or tap here to enter text.

**Website:** Click or tap here to enter text.

**Would you like to be added to an approved provider list that is disbursed to law enforcement and district attorney advocates for referral purposes?**

 **Yes** [ ]

 **No**[ ]

1. **Describe your expertise in working with crime victims:** Click or tap here to enter text.
2. **Identify the primary age of your clients, your specialties and preferred treatment modalities:** Click or tap here to enter text.
3. **Are you willing to accept the CVC pay fee schedule (see mental health packet) as payment in full for mental health sessions:** Click or tap here to enter text.

**If not, are you willing to make other fee adjustments under certain circumstances? If yes, please explain:** Click or tap here to enter text.

1. **Please list your degree(s) and year(s) of graduation:** Click or tap here to enter text.

**Institution:** Click or tap here to enter text.

**License Number: (Please attach a current license to this questionnaire):** Click or tap here to enter text.

 **If unlicensed, you are supervised by (if applicable):** Click or tap here to enter text.

**Supervisor’s contact information:** Click or tap here to enter text.

**Supervisor’s License number:** Click or tap here to enter text.

1. **Identify course work or workshops you have completed concerning crime victimization:** Click or tap here to enter text.
2. **Please check below any of the following services which you provide:**

[ ]  **In person sessions**

[ ]  **Teletherapy sessions, if using Teletherapy please list type of HIPPA approved platform that you use:** Click or tap here to enter text.

[ ]  **Christian counseling**

[ ]  **Treatment of developmentally delayed victims**

[ ]  **Treatment of head-injured victims**

[ ]  **Treatment of hearing-impaired victims**

[ ]  Alternate language If so, indicate language(s): Click or tap here to enter text.

[ ]  **EMDR**

[ ]  **Thought Field Therapy**

[ ]  **Equine-Assisted Therapy**

[ ]  Treatment of a particular gender or age group If so, please explain: Click or tap here to enter text.

[ ]  **Perpetrator treatment**

[ ]  **Other Please list:** Click or tap here to enter text.

1. **Please list which, if any, insurance companies that you accept (including Medicaid/Medicare):** Click or tap here to enter text.
2. **If you are a provider outside of the state of Colorado, please provide the name and contact information for your state regulatory agency:** Click or tap here to enter text.
* **Please note that referrals are not made through this Crime Victim Compensation Program.**
* **Providers are added to an approved provider list that is distributed to law enforcement and District Attorney advocates in the First Judicial District, to provide direct referrals to crime victims.**
* **All questions must be completed to be considered for approval.**

**Please return to:**

**Crime Victim Compensation Program**

**E-mail:** **da-cvc@jeffco.us**

**or**

**Fax: 303-271-6785**