**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 |

**Perpetrator/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:**

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

Click to enter text |
| 1. Describe progress (accomplishments of original goals) related to initial mental health treatment plan:

Click to enter text |
| 1. Reasons for additional treatment:

Click to enter text  |
| 1. Please describe any changes, in treatment plan or approach, that will be taken to meet treatment goals.

Click to enter text |
| 1. List the treatment modalities used to achieve these goals.

Click to enter text |
| 1. 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. |
| 1. 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:**Click or tap here to enter text.- Individual Sessions (maximum of 15)– primary victims and secondary victims on homicide cases only. |

|  |
| --- |
| **VICTIM/CLIENT SIGNATURE SECTION:** |
| I have reviewed the Treatment Plan with my therapist and agree with this plan and the estimated number of sessions.I understand that the CVC Board approves therapy sessions related to the crime for which I have applied, and which is part of the above submitted treatment plan. Treatment for anything other than the crime for which I have applied cannot be paid by CVC.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Victim/Client or Parent/Guardian Signature Date |
| **THERAPIST SIGNATURE SECTION:**  |
| I have read and understand the Mental Health Provider Guidelines as provided to me by the 1st Judicial District Crime Victim Compensation Program.I agree to only bill for sessions and services that are allowable pursuant to the Bylaws and Policies of the 1st Judicial District and outlined in the Mental Health Provider Guidelines.I understand that CVC is, by statute (C.R.S. § 24-4.1-110), the payer of last resort, and I agree to submit bills to insurance when applicable.I further agree to only bill CVC for sessions that are related to the crime for which my client has applied, and which are part of the above submitted treatment plan.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Therapist Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Supervising Therapist Signature Date |

**Please submit this extension request with signatures (required) to:**

**Email:** da-cvc@jeffco.us

**Fax:** 303.271.6785

**Mail:** Colorado First Judicial District Attorney

Attn: Crime Victim Compensation Board

500 Jefferson County Parkway

Golden, CO 80401

\*Updated 5/1/2024