



**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:**

**CLIENT INFORMATION:**

**Name:**

**Parent/Guardian:**

**Address:**

**Telephone No:**

**Current living situation:**

**THERAPIST INFORMATION:**

**Name/Agency:**

**Address:**

**Telephone No:**

**License No & Type:**

**Supervisor Name (if applicable):**  
**Address:**

**Telephone No:**  
**Supervisor License No & Type:**

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

**Company:**  
**Policy No:**  
**Telephone No:**  
**Type of Mental Health Coverage:**

(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.**

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

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

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

Please complete the section below:

**\*\*PLEASE NOTE: The Board will consider no more than 20 sessions at a time.**

# additional **individual / family therapy** sessions needed to complete therapy at \$90 per session.

# additional **group** sessions needed to complete therapy at \$40 per session.

# additional **individual / family therapy** sessions needed to complete therapy at \$45 **intern** rate per session.

**Frequency of sessions:**

1x a week                       Other – please explain –

\$\_\_\_\_\_ **TOTAL ANTICIPATED COST OF EXTENDED TREATMENT**

Both the claimant and the therapist must sign this form.

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Claimant Signature

Date

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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