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.

______________________________	______________________________
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