CRIME VICTIM COMPENSATION BOARD
SECOND JUDICIAL DISTRICT
201 W. COLFAX AVE., DEPT. 801
DENVER, CO 80202
720-913-9253
720-913-9035 (Fax)

REQUEST TO EXTEND COUNSELING / RESUME COUNSELING

All handwritten treatment plans will be returned without being reviewed by the Board. If you would like an electronic copy of this from please email us at :
Victimcomp@denverda.org.

Approval of initial therapy or submission of this form **does not guarantee payment** for extended treatment. Any and all treatment costs that exceed the Board award are the responsibility of the claimant.

Client Information:
Name: Claim#
Parent/Guardian:
Address:

Telephone:

Therapist Information:
Name: Supervisor:
Address:

Telephone: Telephone:
Counseling License No.:
Supervisor's Name: Supervisor License No.:

Insurance information:

All bills must be submitted to the victim's insurance company or other third party payer prior to being submitted to the Board. The board will only approve that amount for which the victim is directly responsible.

Does the client have mental health coverage included with insurance?
Yes___________ No____________
Are you a provider for this insurance carrier? Yes _______ No________
Have you billed insurance? Yes_________ No____________

Insurance company name:___________________________

Insurance coverage for mental health:_________________

Treatment Planning:

1. Behavioral and emotional symptoms being displayed by the victim related to this crime?

2. Describe the progress the client has made in treatment.

3. Reason for extension request.

4. Changes in treatment goals, each goal should have a target date of completion.

5. Prognosis:

6. What other recommendations or treatment referrals might be made (i.e. psychological assessment, group therapy, family therapy, psychiatric evaluation for medication, etc.)

7. If treatment needs exceed the limits of the Crime Victim Compensation Program, what is your plan for transitioning this client to other treatment.

Estimated length of extension:

Number of sessions to date:_____

Requested # of individual sessions:______
Requested # of family sessions:_______
Requested # of group sessions_______

Anticipated termination date:_______

I hereby attest that the information contained herein is correct to the best of my knowledge and belief, and all treatment for which I am requesting payment through the Crime Victim Compensation Program is related to the criminal incident under which my client's claim was approved.

______________________________ ______________________________
Therapist Signature **Victim or Parent / Guardian Signature**

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Supervisor