**17th JUDICIAL DISTRICT   
CRIME VICTIM COMPENSATION BOARD**

**MENTAL HEALTH PROVIDER QUESTIONNAIRE**

Crime Victim Compensation Board   
1000 Judicial Center Drive, Suite 100  
Brighton, Colorado, 80601  
  
Telephone: 303-835-5690  
Fax: 303-835-4165

Email: vcomp@da17.state.co.us

The 17th Judicial District Crime Victim Compensation Board requires the completion of the following questionnaire to be on file prior to disbursement of compensation funds for mental health therapy. Your cooperation in completing and returning this questionnaire is greatly appreciated. Handwritten forms will not be accepted.

Prior to completing this questionnaire, please review the Mental Health Provider Guidelines found on our website [www.crimevictimcompensation.org](http://www.crimevictimcompensation.org) under the Service Providers tab. This document goes over everything you need to know when working with CVC in the 17th Judicial District, including the Therapist Qualifications.

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| **THERAPIST CONTACT INFORMATION SECTION** | |
| Therapist name: Click or tap here to enter text. | |
| Practice Name: Click or tap here to enter text. | |
| Physical Practice Address/City/State/Zip: Click or tap here to enter text. | |
| Mailing Address/City/State/Zip: Click or tap here to enter text. | |
| Practice telephone: Click or tap here to enter text. | |
| Therapist email: Click or tap here to enter text. | Website: Click or tap here to enter text. |
| What name should checks be made to? Click or tap here to enter text. | |

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| **THERAPIST QUALIFICATIONS SECTION** |
| Are you a licensed therapist?  Yes  No |
| If yes, what is your active license number? Click or tap here to enter text. |
| If no, do you have a minimum of a master’s degree?  Yes  No |
| Please list your degree(s) and year(s) of graduation and institution(s): Click or tap here to enter text. |
| Supervised by (if applicable): Click or tap here to enter text. |
| Supervisor’s active license number: Click or tap here to enter text. |

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| **THERAPIST EXPERIENCE AND SERVICE SECTION** | | |
| Please list any specialized training or experience you have working crime victims.  Click or tap here to enter text. | | |
| List specific treatment services that you offer to crime victims. For instance, individual, non-offending parent, group, etc.  Click or tap here to enter text. | | |
| List treatment modalities you prefer to utilize. (EMDR, CBT, biblio-therapy, play therapy, etc.)  Click or tap here to enter text. | | |
| Please identify any area of specialization you are trained for and provide services in. For example, child victims of sexual assault.  Click or tap here to enter text. | | |
| Please check below if there are specific populations of clients you prefer to work with: | | |
| children | adolescents | adults |
| elderly | women | men |
| LGBTQ+ | other: Click or tap here to enter text. | |
| Please indicate the types of victimization you prefer to work with: | | |
| child abuse/neglect | incest | sexual assault |
| domestic violence | stalking / harassment | theft / robbery |
| motor vehicle accidents | homicide | general trauma |
| Please indicate what special populations you serve: | | |
| mental illness | physical disabilities | hearing impaired |
| visually impaired | other: Click or tap here to enter text. | |
| Please indicate what languages, other than English, that you provide service in: | | |
| Spanish | French | Portuguese |
| Italian | Arabic | American Sign Language |
| Japanese | Russian | Korean |
| Other: Click or tap here to enter text. | | |
| In case of an emergency, do you have a way that clients can contact you 24 hours a day, 7 days a week?  Yes  No | | |

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| **BILLING SECTION** | | |
| You may bill clients at your customary rate however, for our records, do you plan to accept the 17th Judicial District Crime Victim Compensation Program fee schedule as payment in full?  Yes  No | | |
| **17th Judicial District Crime Victim Compensation Program Payment Schedule** | | |
| **Type of session** | **Maximum per session** | **Length of session** |
| Individual sessions | $140.00 | 45 minute minimum |
| Family sessions | $70.00 | 45 minute minimum |
| Group sessions | $70.00 | 45 minute minimum |

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| **INSURANCE SECTION** | | |
| Please check all the following insurance providers you accept: | | |
| Aetna | Great West | United Healthcare |
| Kaiser Permanente | Anthem | Medicaid |
| I do not accept insurance | Other: Click or tap here to enter text. | |

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| **PROVIDER PORTAL** |
| Are you interested in signing up for access to our online provider portal, which would allow you to submit invoices and treatment plans directly into your client’s online claim file? |
| Yes, I would like to sign up for portal access.  No, I prefer to submit invoices and treatment plans via mail, email, or fax. |

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| **AGREEMENTS SECTION** | | | |
| I have read and understand the Mental Health Treatment Provider Guidelines as provided to me by the 17th 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 17th Judicial District and outlined in the Mental Health Treatment Provider Guidelines.  I understand that CVC is, by statute (C.R.S. § 24-4.1-110), the payer of last resort, and 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 an approved treatment plan or treatment plan extension. | | | |
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| Therapist Signature |  | | Date |
| I hereby certify that I am actively supervising the above-named therapist and am responsible for services / treatment rendered under their care. | | | |
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| Supervising Therapist Signature |  | | Date |

Please attach your license and/or your supervisor’s license

and return along with this form to:

[vcomp@da17.state.co.us](mailto:vcomp@da17.state.co.us)