Crime Victim Compensation Board
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**17th JUDICIAL DISTRICT
CRIME VICTIM COMPENSATION BOARD**

**MENTAL HEALTH TREATMENT PLAN**

**EXTENSION REQUEST**

* Prior approval of crime related mental health treatment and/or submission of this form does not guarantee payment of additional mental health treatment services.
* Any treatment costs exceeding the approved amount determined by the Board are the responsibility of the victim/claimant.
* The victim claimant will be notified in writing of the Board’s decision after review of this treatment plan extension request.
* Handwritten forms will be returned without being reviewed.
* The client or parent/guardian must sign the form before submission.

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| **CLIENT INFORMATION SECTION** |
| CVC Claim number: Click or tap here to enter text. |
| Name: Click or tap here to enter text. | DOB: Enter birth date |
| Address: Click or tap here to enter text. |
| City / State / Zip: Click or tap here to enter text. |
| Client’s Parent / Legal Guardian (if under 18 y.o.): Click or tap here to enter text. |

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| **FAMILY INFORMATION SECTION** |
| List family members that will be involved in treatment related to the victimization and respective therapist name (sessions involving the defendant/perpetrator will not be covered): Click or tap here to enter text. |

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| **PERPETRATOR INFORMATION SECTION** |
| Name (**required**, if known by victim): Click or tap here to enter text. |
| Relationship to victim: Click or tap here to enter text. |
| What contact does the perpetrator currently have with the victim/client? Click or tap here to enter text. |

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| **THERAPIST INFORMATION SECTION** |
| Name: Click or tap here to enter text. | License Number: Click or tap here to enter text. |
| Address: Click or tap here to enter text. |
| City / State / Zip: Click or tap here to enter text. |
| Email: Click or tap here to enter text. |
| Supervisor’s Name: Click or tap here to enter text.  | License Number: Click or tap here to enter text. |

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| **TREATMENT PLANNING SECTION** |
| Briefly describe the crime:Click or tap here to enter text. |
| What ongoing behavioral and/or emotional symptoms, directly related to the crime, are currently being displayed by the victim/claimant?Click or tap here to enter text. |
| Describe progress related to the initial Mental Health Treatment Plan goals/objectives.Click or tap here to enter text. |
| Please list any new changes to treatment goals/objectives relative to the victimization. Each goal should have an estimated completion date.Click or tap here to enter text. |
| Discuss treatment modalities used to achieve these goals.Click or tap here to enter text. |
| CVC funds are limited. What is your plan for transitioning this client to other treatment or pay sources if necessary?Click or tap here to enter text. |

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| **INSURANCE INFORMATION SECTION** |
| Does the victim have insurance? [ ]  Yes [ ]  No |
| Do you accept the victim’s insurance? [ ]  Yes [ ]  No |
| Insurance company name: Click or tap here to enter text. |
| Policy number: Click or tap here to enter text. |
| \*Please include a copy of the Explanation of Benefits (EOB) with invoices that have been billed to insurance. If insurance is available but is not going to cover services, a letter of denial must be provided. |

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| **ESTIMATED LENGTH OF TREATMENT SECTION** |
| Number of sessions to date: Enter number |  |
| Maximum amount the Board will consider upon submission of this Treatment Plan Extension request: $3080.00 for PRIMARY VICTIMS $1540.00 for SECONDARY VICTIMSWhat number of sessions would you like the Board to consider? |
| **Number of sessions** | **Type of sessions** | **Maximum per session** | **Total** |
| Enter number | Individual sessions | $140.00 | $ Enter total |
| Enter number | Family sessions | $70.00 | $ Enter total |
| Enter number | Group sessions | $70.00 | $ Enter total |
|  |  | **TOTAL AMOUNT REQUESTED** | $  **Enter total** |
| Anticipated termination date: Enter date |
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| **VICTIM/CLIENT SIGNATURE SECTION** |
| [ ]  I have reviewed the Treatment Plan with my therapist and agree with this plan and the estimated number of sessions and cost.[ ]  I understand that the CVC Board awarded 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.  |
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| Victim/Client or Parent/Guardian Signature |  | Date |
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| **THERAPIST SIGNATURE 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 the above submitted treatment plan.  |
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| Therapist Signature |  | Date |
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| Supervising Therapist Signature |  | Date |
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