

Victim Compensation Board Department 5031 P.O. Box 20,000 Grand Junction, Colorado, 81502 Telephone: 970-244-1730

Fax: 970-256-1432 Email: victims.comp@mesacounty.us

This form is to be used only after the sessions approved under the initial assessment and treatment plan near termination. All Therapy Extension Requests must be returned to the Crime Victim Compensation program 30 days PRIOR to the initial projected termination date.

Prior approval for crime related mental health treatment and/or submission of this form does not guarantee payment of additional mental health treatment services. You will be notified in writing of all Board decisions. All treatment costs exceeding the approved amount determined by the Board are the responsibility of the claimant. This form may be emailed to you for convenience.

	DOB:
ddress:	
Lity/State/Zip:	
lient's Parent/Legal Guardian (if under 18):	
HERAPIST INFORMATION:	
Jame:	
susiness Address:	
city/State/Zip:	
elephone Number:	Fax Number:
mail:	
upervisor Name:	License No
CLIENT TREATMENT INFORMATION:	
ate Treatment Began:	Number of Sessions to Date:
Pate of Crime: Typ	
s the presenting issue related to the crime listed above	ve? No Yes
reatment Modalities to be Used:	
	her:
	reatment plan's goals/objectives (use objectives from initial treatment plan):

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2. Please describe the behavioral and emotional symptom	s currently displayed by the victim:
3. Please list any new or changes to treatment goals/object	etives:
4. How do the changes in the treatment plan relate to the	crime?
Number of additional sessions requested:	
6. Frequency of therapeutic contacts:	
7. New date of discharge with this patient:	
CLIENT INSURANCE INFORMATION: Has the Victim's insurance status changed since the initial treat. If 'Yes', how?	ment plan? No Yes
	Group Number:
of my client, if eligible. I understand that Crime Victim Compensation	or of last resort, and I further agree to apply for any primary insurance benefits can only pay for the client's out of pocket amount as indicated by insurance. I are part of the above submitted treatment plan. I agree not to bill Crime Victim
The information contained herein is correct to the best of my knowleds I am a licensed therapist, or under the supervision of, who has experie	
I will accept the Board's reimbursement of \$150 per hour and \$75 per for neurofeedback as payment in full; and, I will request any necessar	half hour for individual and family therapy, \$50 for group therapy, and \$80 y extension 30 days prior to the termination date of any award made.
I swear and affirm under the penalty of perjury that the statements here	in are true and correct to the best of my knowledge and belief.
Therapist Signature	Date
Therapist Supervisor Signature	Date
Client/Guardian Signature	- Date

Once the Board has made an approval you will be notified in writing. The Board processes and issues payments only once a month, therefore payment could take up to 30 days after receiving an itemized bill/invoice.

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