Crime Victim Compensation Board

Twenty-Third Judicial District of Colorado

PHONE: (720) 733 - 4580
FAX: (720) 733 - 4672
EMAIL: DAVICTIMCOMP@CODA23.GOV

PROUDLY SERVING DOUGLAS, LINCOLN AND ELBERT COUNTIES

Extend Treatment Plan

PLEASE COMPLETE ALL FIELDS. INCOMPLETE TREATMENT PLANS WILL NOT BE REVIEWED.

NOTE: Completion of this form does not guarantee approval of a claim. Due to claim volume, treatment plans typically take 30-45 days to process.

SECTION 1 – CLIENT INFORMATION

Client Name: ______________________________

Date of Birth: ______________________________

Parent/Guardian Name: ______________________________

Mailing Address: ______________________________

City: ____________________ State: ____________________

Zip Code: ______________________________

Telephone Number: ______________________________

Client's current living situation: ______________________________

Is this client the primary victim? ☐ YES ☐ NO

SECTION 2 – THERAPIST INFORMATION

Therapist Name: ______________________________

Agency: ______________________________

Mailing Address: ______________________________

City: ____________________ State: ____________________

Zip Code: ______________________________

Telephone Number: ____

Email: ____

License Number: ________________________ License Type: __________________________

SECTION 3 – SUPERVISOR INFORMATION

Complete this section only if you are unlicensed or an intern. Check not applicable if you do not require supervision.

☐ NOT APPLICABLE

Supervisor Name: ____

Agency: ____

Telephone Number: ____

Email: ____

License Number: ________________________ License Type: __________________________

SECTION 4 – CLIENT INSURANCE INFORMATION

Complete this section only if the client had a change in insurance coverage since the initial treatment plan was submitted.

Does the client have insurance? ☐ YES ☐ NO

Insurance Provider: ____

Policy Number: ____

Telephone Number: ____

Are you paneled with the client's insurance provider? ☐ YES ☐ NO

Deductible Amount: ____

Client's co-pay after deductible is met: ______________________________

SECTION 5 – TREATMENT

5.1) Describe the client's current symptomology as it relates directly to their victimization:

5.2) Describe the client's progress toward their original treatment goals:

Goal 1:

Goal 2:

Goal 3:

5.3) Describe the reason(s) you are requesting ongoing treatment for this client:

5.4) List and describe any changes made to the initial treatment plan goals, if any:

5.5) If the client previously disengaged from treatment for a period of three (3) months or longer describe the reason(s) the client is returning to treatment as it relates directly to their victimization:

5.6) Is there any additional information you would like the Board to consider?

SECTION 6 – REQUEST FOR SESSIONS

NOTE: The Board will NOT consider more than 25 sessions at one time.

__________ Number of Individual/Family Sessions: $120.00/hour

__________ Number of Individual/Family Sessions INTERN Rate: $60.00/hour

__________ Number of Group Sessions: $40.00/hour

TOTAL COST OF TREATMENT: ____

REVIEW AND SIGN

This form must be signed by the client (or parent/guardian if the client is under the age of 18), the therapist, and the therapist's supervisor if applicable. Unsigned forms will be returned to the therapist and may result in delays in processing.

Client Signature Date

Therapist Signature Date

Supervisor Signature Date

PLEASE RETURN COMPLETED FORMS TO:
OFFICE OF THE DISTRICT ATTORNEY
C/O CRIME VICTIM COMPENSATION
4000 JUSTICE WAY, SUITE 2525 A
CASTLE ROCK, CO 80109
EMAIL: DAVictimComp@coda23.gov
FAX: (720) 733 - 4672