**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: Click or tap here to enter text.

Date of Birth: Click or tap here to enter text.

Parent/Guardian Name: Click or tap here to enter text.

Mailing Address: Click or tap here to enter text.

City: Click or tap here to enter text. State: Click or tap here to enter text.

Zip Code: Click or tap here to enter text.

Telephone Number: Click or tap here to enter text.

Client’s current living situation: Click or tap here to enter text.

Is this client the primary victim? Choose an item.

**section 2 – therapist information**

Therapist Name: Click or tap here to enter text.

Agency: Click or tap here to enter text.

Mailing Address: Click or tap here to enter text.

City: Click or tap here to enter text. State: Click or tap here to enter text.

Zip Code: Click or tap here to enter text.

Telephone Number: Click or tap here to enter text.

Email: Click or tap here to enter text.

**License Number:** Click or tap here to enter text. License Type: Click or tap here to enter text.

**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: Click or tap here to enter text.

Agency: Click or tap here to enter text.

Telephone Number: Click or tap here to enter text.

Email: Click or tap here to enter text.

License Number: Click or tap here to enter text. License Type: Click or tap here to enter text.

**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? Choose an item.

Insurance Provider: Click or tap here to enter text.

Policy Number: Click or tap here to enter text.

Telephone Number: Click or tap here to enter text.

Are you paneled with the client’s insurance provider? Choose an item.

Deductible Amount: $Click or tap here to enter text.

Client’s co-pay after deductible is met: $Click or tap here to enter text.

## section 5 – treatment

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

Click or tap here to enter text.

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

Goal 1: Click or tap here to enter text.

Goal 2: Click or tap here to enter text.

Goal 3: Click or tap here to enter text.

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

Click or tap here to enter text.

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

Click or tap here to enter text.

**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:

Click or tap here to enter text.

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

Click or tap here to enter text.

**section 6 – request for sessions**

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

Choose an item. Number of Individual/Family Sessions: $120.00/hour

Choose an item.Number of Individual/Family Sessions INTERN Rate: $60.00/hour

Choose an item. Number of Group Sessions: $40.00/hour

TOTAL COST OF TREATMENT: $Click or tap here to enter text.

## 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, CASTLE ROCK, CO 80109

EMAIL: DAVictimComp@coda23.gov

FAX: (720) 733 - 4672