

Crime Victim Compensation

Eighth Judicial District

201 LaPorte Avenue Ste 200

Fort Collins CO 80521

970-498-7290

www.larimer.org/da/vicwit/compensation.htm

**MENTAL HEALTH EXTENSION REQUEST**

**IMPORTANT:**

1. **This form must be typewritten.**
2. **This form can be sent to you on C.D. from the District Attorney’s or it can be sent to you via e-mail.**
3. **Completion of this form does not guarantee approval of funds.**
4. **For confidentiality purposes please mail back the extension request.**

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| --- | --- | --- | --- | --- |
| Client Name | | Claim Number | Relationship to Primary Victim | |
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|  | | | | |
| Therapist Name | Agency (if applicable) | | | License Number |
|  |  | | |  |
| Email Address | Do you accept the victim’s insurance? | | | |
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| Accomplishments of Original Goals stated in Treatment Plan: | | | | |
|  | | | | |
| On-going behavioral and/or emotional symptoms directly related to crime: | | | | |
| Reasons for Additional Treatment: | | | | |
|  | | | | |
| Current Involvement Between Perpetrator and Victim: | | | | |
|  | | | | |
| Please note, the Board may consider up to two Extension Requests.  Number of additional sessions requested: | | | | |

I understand, swear, and affirm under penalty of perjury the following statements are true and correct to the best of my knowledge and belief:

* The extension request submitted and subsequent treatment billed to Crime Victim Compensation is directly related to the crime in which the claim has been approved.
* The Crime Victim Compensation Board will not be billed for missed/cancelled appointments, trial attendance, report writing, couples counseling, or any session not directly related to the crime in which the claim has been approved.
* Crime Victim Compensation is, by state law, the payor of last resort.
* I will apply for any primary insurance benefits if applicable.
* I shall reimburse the fund up to the total amount of compensation benefits paid which in fact were covered by other means.

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Victim/Guardian Printed Name Victim/Guardian Signature Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_**

Therapist Printed Name and License # Therapist Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_       \_**

Supervising Therapist Printed Name and License # Supervising Therapist Signature Date