19TH JUDICIAL DISTRICT

WELD COUNTY CRIME VICTIM COMPENSATION PROGRAM

EXTENSION REQUEST FORM

* If applicable, this form must be completed thoroughly and submitted **WITHIN THREE SESSIONS OF THE CONTINUED TREATMENT**.

* Submit a **SEPARATE REPORT FORM FOR EACH INDIVIDUAL TREATED**.

* Forms can be sent electronically upon request in a Microsoft Word document.

* **Typed forms are required. Illegible or incomplete forms will slow processing.**

* Mental health providers should keep copies of this form on file, and should not expect notices concerning the submission of reports.

Client Name: _____ DOB: _____

Related Client Name(s): _____

Therapist: _____

Clinical Supervisor: _____

1. Number of sessions to date: Individual _____ Family_____ Group _____

Other _____ Explain: _____

2. Describe the client's progress to date for previously listed goals **(please refer to goals and objectives described on initial treatment plan).**

3. Describe client issues to be addressed in future sessions, including estimated number of sessions.

4. Have any other issues presented, not related to this specific request, since the beginning of therapy?

Crime Victim Compensation will not pay for the following: missed/cancelled appointments, trial attendance, report writing, marital counseling, and sessions that are not primarily dealing with issues directly related to the criminal justice incident for which the client is applying. Any lapse of treatment over six months will require a new treatment report and approval from the Board.

I understand that Crime Victim Compensation is, by state law, the payer of last resort, and I further agree to apply for any primary insurance benefits of my client, if eligible. I understand that Crime Victim Compensation can only pay for the client's out of pocket amount as indicated by insurance. I further agree to only bill Crime Victim Compensation for sessions that are part of the above submitted treatment plan. I agree not to bill Crime Victim Compensation for treatment outside of the above treatment plan.

I swear and affirm under the penalty of perjury that the statements herein are true and correct to the best of my knowledge and belief.

Therapist: _____ Date: _____

Supervisor: _____ Date: _____

Claimant: _____ Date: _____

Please return form to: Crime Victim Compensation, PO Box 1167, Greeley, CO 80632 or
Fax (970) 336-7224 or e-mail weldvictimcompensation@weldgov.com