South Carolina Attorney General's Office
South Carolina Crime Victim Services Division
Department of Crime Victim Compensation (DCVC)

DCVC Additional Counseling Sessions Request Form

Today's Date: ____/____/_____ Date of this victim's first session: ____/____/_____

- This form must be submitted to request approval/pre-authorization for payment of additional sessions beyond the initial 20 sessions
- Approval/pre-authorization is contingent upon the rationale behind the need and the details provided.
- The information provided must include a goal-directed treatment plan and a summary of your assessment toward meeting those goals.

Specific training and qualification: The provider must be a Licensed Mental Health Professional, who has received specific training in evidence-based treatment that has been shown to be effective in meeting the needs of criminal victimization on adults, children and families.

Crime Victim Information

Victim's Legal Name: _____

Claimant (if a different person): _____

Claim #: _____ Crime Date: _____

Diagnosis Information

What is your diagnosis?_____
Briefly describe the symptoms/conditions you are treating that are a **direct** result of the crime.

Provide the multiaxial diagnosis: _____

Treatment Plan

Has there been substantial progress toward recovery from the crime related condition? Yes ____ No ____
Estimate treatment duration: From: ____/____/____ To: ____/____/____
How many additional sessions are you requesting? _____
What is your evidence-based treatment model? _____
What is your training in the use of this model? _____
What is your plan for termination? _____
_____

Provider Information

Provider must furnish the following information. The victim must sign and date this form.
Print name: _____License type and number: _____
Name of Facility/Business: _____Phone Number: _____
Victim/Claimant signature and date: _____