

Archdiocese of Philadelphia
Victim Assistance Project

Mental Health Service Provider Certification Form

Victim Survivor Name:
Other Identifying Information:
Relationship to the victim/survivor:

The following information is requested from a licensed provider of mental health services. This information is necessary to approve the continued payment of bills for a second or subsequent 12 month period.

Mental Health Practitioner's Name: _____

Circle one: M.D. Ph.D. M.A. M.S. L.S.W. L.C.S.W. Other: _____
License No. _____

If the therapist is being supervised by the licensed provider please provide the name and license number of the supervisor.

1. What are the estimated costs of treatment over the next twelve months? \$ _____

2. What portion of the treatment being provided is a direct result of the sexual assault?
If less than 100% please tell us what percentage if related to the sexual assault.

CERTIFICATION:

I hereby certify that all of the foregoing statements are true and correct to the best of my knowledge, information and belief. This verification is made subject to the penalties of 18 Pa. C.S.A. Section 4904, relating to unsworn falsifications.

DATE: _____

SIGNATURE: _____

Please return completed form to:

Archdiocese of Philadelphia
Victim Assistance Program
222 North Seventeenth Street
Philadelphia, PA 19103-1299