



**CHANGE the conversation.**

Preventing and Healing Child Sexual Abuse.

**Counseling Grants – Additional Funding Requested**

Name of Organization or Practice: \_\_\_\_\_ Clinician Name: \_\_\_\_\_ Client Unique Id: \_\_\_\_\_

How long the client has been in treatment (not on the counseling grant but in therapeutic treatment):

Please describe any progress made during treatment:

Please describe why additional funding is being requested:

Please list any changes to their household income or insurance coverage since original grant approval:

Please describe any additional therapeutic benefits a grant extension provide:

How many additional sessions are you requesting and at what rate per session:

Additional feedback or information that you would like to provide.

Completed by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Approved: YES NO Additional Sessions: \_\_\_\_\_ Rate per session: \_\_\_\_\_  
Original # of sessions approved: \_\_\_\_\_ New total # of sessions approved: \_\_\_\_\_ New total award: \_\_\_\_\_