

# Second Wind Fund, Inc.

## CLAIM FORM

I hereby submit the following claim for payment to Second Wind Fund, Inc.  
 I understand that all claims must be submitted **within 60 days of service.**

**SWF Client Referral Number:** \_\_\_\_\_

Date of Service	Session #	Cancellation/No Show Two reimbursed at \$45 each. Does not count toward 12 sessions total	Address or school name of <b>off-site visit only.</b> <b>Must travel a minimum of 2 miles for \$20 reimbursement per trip.</b>

**Suicidal Ideation Questionnaire (SIQ) Surveys Returned**

Reimbursement is \$20 after 2 SIQ's are submitted and total of \$30 for all 3.

		Surveys submitted with this claim	*Reason not administered
<b>SIQ # 1</b>	Administered session #1		
<b>SIQ # 2</b>	Administered session #5		
<b>SIQ #3</b>	Administered last session		

\*If not administered please explain why: child refused, language barrier, age, inappropriate timing clinically, will submit all at end, provider lacked forms, etc.

\_\_\_\_\_  
**Signature of Therapist**

\_\_\_\_\_  
**Date**

**Therapist Name and Address:** If check is written to your business, please also include your name.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**New Address? Please submit a new W-9 Form**

**Phone:** \_\_\_\_\_

**Payment via (please select one):**

- Check
- bill.com (email SWF for activation code)

Office Use Only:

Ther: _____	
Trav: _____	County: _____
SIQ: _____	Appr. _____
Total: _____	

**Please send to: Second Wind Fund, Inc**  
**Email: [program@thesecondwindfund.org](mailto:program@thesecondwindfund.org)**  
**Phone: 720-962-0706**  
**Fax: 720-962-0821**