APPLICATION FOR MENTAL HEALTH SERVICES

Information Related To Eligibility Regarding The USVI Mental Health Fund

Do you fall into one of the below categories? CHECK **EACH** CATEGORY THAT IS APPLICABLE TO YOU (you may check more than one box) *

- [ ] Participating Claimant of the settlement of Jane Doe 1 v. JP Morgan Chase Bank, N.A. ("JPM Class Action") ⓘ
- [ ] Participating Claimant of the settlement of Jane Doe 1 v. Deutsche Bank Aktiengesellschaft, et al. ("DB Class Action") ⓘ
- [ ] A Class Member of the JPM Class Action
- [ ] A Class Member of the DB Class Action
- [ ] A participant in the Epstein Victims' Compensation Fund
- [ ] I do not fall into at least one of the above categories

Please explain why you believe you are eligible to apply to the Mental Health Fund. Please review the website www.USVIMentalHealthFund.com where eligibility requirements are explained in detail.

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FOR MORE INFORMATION

Call 516-850-5125
Email simone@simonelelchuk.com
Mail Simone Lelchuk
c/o FREJKA PLLC
415 East 52nd Street, Suite 3
New York, New York 10022

Applicant Name & Contact Information

Current Legal Name *

Previous Name (at time of sexual abuse by Jeffrey Epstein)

Country *

US

Mailing Address Line 1 *

Mailing Address Line 2

City *

State *

ZIP Code *

Email

Phone Number

How do you prefer we communicate with you? (check all that apply)

- [ ] **Mail**
- [ ] **Email**
- [ ] **Phone**

Note: It is important that you inform the Claims Administrator if you move or change email address or phone number.

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Treatment Plan

Name of Mental Health Care Provider*

Country *

US

Address of Provider Line 1 *

Address of Provider Line 2

City *

State *

ZIP Code *

Email Address of Provider

Phone Number of Provider

In addition to completing the information above, please submit a signed letter from your mental health care provider (the "Provider") on the Provider's letterhead with a proposed treatment plan that includes the following information:

- The treatment period recommended by the Provider;
- The number of sessions per week or month the Provider recommends;
- The rate per session the Provider charges;
- Wire transfer instructions for the Provider, the Provider's signed IRS Form W-9 (if US based), and the currency (US Dollars, Euros, Pound Sterling, etc.); and
- Whether there are other treatments a Provider recommends (e.g., inpatient facility, consultation with a psychiatrist, etc.). If yes, please make sure the Provider includes necessary details for the Claims Administrator to consider. Please note that the Claims Administrator understands that this is an initial treatment plan, and your needs may change over time. Therefore, the treatment plan may be amended subject to the Claims Administrator's approval.

Please include a copy of your Provider's credentials/licensing as part of your submission.

You may upload as many documents as necessary one at a time. Please upload files in one of the following formats and click "Save": .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tiff, .tif, .doc, .docx, .xls, .xlsx, .csv, .rtf

Choose File | No file chosen

Cancel | Save

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Summary

Applicant Name & Contact Information

Current Legal Name	
Previous Name	
Mailing Address - Line 1	
Mailing Address - Line 2	
City	
State	
ZIP Code	
Country	
Phone Number	
Email Address	
How Do You Prefer We Communicate With You?	

Supporting Documents

File name
File.PDF

Certification:

By signing below, you acknowledge and agree that the USVI Mental Health Fund will pay the Provider directly for services rendered to you, provided that you obtain prior approval of your treatment plan from the Claims Administrator before beginning treatment and that subject to extension, your treatment is completed on or before June 30, 2026. ABSENT EXTENUATING CIRCUMSTANCES, PLEASE NOTE THAT THE USVI MENTAL HEALTH FUND WILL NOT PAY THE PROVIDER IF YOU MISS A SESSION OR DISCONTINUE TREATMENT. The Claims Administrator recommends that you familiarize yourself with your Provider's cancellation policy and obtain a clear understanding of whether you will be charged a fee in the event you miss a session due to illness or otherwise.

Signature *

Date

02/23/2022 - [Time Zone Configured From CMS]

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Submit

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