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
- [x] I do not fall into at least one of the above categories

Please explain why you believe you are eligible to apply to the USVI 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 (212) 641-0848
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 *

This is required.

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

Country *

United States of America

Mailing Address Line 1 *

This is required.

Mailing Address Line 2

City *

This is required.

State *

Please select an option

This is required.

ZIP Code *

This is required.

Email *

This is required.

Phone Number *

This is required.

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

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

Please select at least one category.

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 *

This is required.

Country *

United States of America

Address of Provider Line 1 *

This is required.

Address of Provider Line 2

City *

This is required.

State *

Please select an option

This is required.

ZIP Code *

This is required.

Email Address of Provider *

This is required.

Phone Number of Provider *

This is required.

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.

Please upload a file in one of the following formats and click "Upload": .bmp, .gif, .jpg, jpeg, .pdf, .png, .tiff, .tif, .doc, .docx, .xls, .xlsx, .csv, .rtf. You may upload files up to 50MB large, up to 500MB total. If you have additional or larger files to provide, please contact us at simone@simonelelchuk.com.

Choose File No file chosen

Cancel Upload

This is required.

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New York, New York 10022

Summary

Applicant Name & Contact Information

Current Legal Name	TESTID10049
Previous Name	
Mailing Address - Line 1	Mailing Address Line 1
Mailing Address - Line 2	
City	City
State	AL
ZIP	11111
Country	US
Phone Number	(206) 867-5309
Email Address	andrew.matias@jndla.com
How do you prefer we communicate with you?	Mail, Email, Phone

Supporting Documents

File name
43MB - c5819637-d50e-4fca-b87f-a463322a0cd3_2 - Copy (2).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 January 15, 2028. 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 *

This is required.

Date
02/21/2025 - Eastern Standard Time

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New York, New York 10022

SUCCESS ✓

Your Application has been submitted successfully.

Your Reference Number is: **PW5ZHQK64S**

Please be patient while the Claims Administrator processes the applications submitted. If you wish to make any changes to the claim after submission, please contact the Claims Administrator.

Applicant Name & Contact Information

Current Legal Name	TESTID10049
Previous Name	
Mailing Address - Line 1	Mailing Address Line 1
Mailing Address - Line 2	
City	City
State	AL
ZIP	11111
Country	US
Phone Number	(206) 867-5309
Email Address	andrew.matias@jndla.com
How do you prefer we communicate with you?	Mail, Email, Phone

Supporting Documents

File name
43MB - c5819637-d50e-4fca-b87f-a463322a0cd3_2 - Copy (2).pdf

Please keep your Reference Number. Thank you.

You may print these details and keep a copy for future reference by clicking the "Print" button below.

Print

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