

# C.O.P.S. Kids Counseling Application



Parent or Guardian Name \*

First

Last

Mailing Address \*

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Country

Home Phone

 -  - 

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###

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Cell Phone \*

 -  - 

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###

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Email \*

Please check the box if you have other insurance that will pay a portion of the counseling fees.

☐ I have other insurance that will pay a portion of the counseling fees.

## Patient Information

Patient's Name \*

First

Last

Patient's Date of Birth: \*

 /  /  

MM

DD

YYYY

Please Attach a Birth Certificate or Other Proof of Age \*

No file chosen

**Name of Patient's Counselor/Doctor \***

First

Last

**Counselor/Doctor's Mailing Address \***

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Country

**Email \*****Phone Number \*** -  - 

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## Fallen Officer's Information

**Deceased Officer's Name \***

Title

First

Last

Suffix

**Date of Death \***

/

/



MM

DD

YYYY

**Department: \*****Department Address**

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Country

**Was this a Line of Duty Death? \***

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I understand that the "C.O.P.S. Kids" program is designed to assist with the counseling fees for children of officers whose deaths are considered "In the Line-of-Duty" as determined by the FBI and the Public Safety Officers' Benefits Act and that C.O.P.S. may have to contact the above police department to verify this fact.

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