GEORGIA CRIME VICTIMS COMPENSATION PROGRAM
CRIMINAL JUSTICE COORDINATING COUNCIL
104 MARIETTA STREET, SUITE 440 ★ ATLANTA, GEORGIA 30303-2743
404.657.2222 ★ 800.547.0060 ★ 404.463.7652 FAX ★ 404.463.7650 TTY

SERIOUS MENTAL AND EMOTIONAL TRAUMA (SMET) VERIFICATION FORM

The Criminal Justice Coordinating Council (CJCC) is responsible for administering the State of Georgia's Crime Victim Compensation Program (CVCP). Recently, a crime victim, who is now a patient under your care, submitted a claim indicating that they suffered a serious mental or emotional trauma relating to a crime. In order to administer funds, CJCC is required pursuant to O.C.G.A.§17-15-2 to have documentation by a licensed mental health professional validating the serious mental or emotional trauma. To assist the CVCP in determining eligibility, we would appreciate your assistance in providing the below information so the CVCP can make the best decision regarding this claim.

Claim Number:

Patient/Victim:

Victim Name:

Victim SSN:

Victim Address:

Victim DOB:

Date of Crime:

1. In your professional opinion, did this client suffer a serious mental or emotional trauma as a result of the crime that occurred on the date indicated above? Yes ☐ No ☐

2. If YES, please describe the nature of the serious mental or emotional trauma:

   _____

   _____

3. Date Treatment Began: _____/_____/_____

4. Agency/Business Name: _____

5. What type of treatment is being provided?

   Medication Management ☐

   Individual counseling ☐

   Family counseling ☐

   Please list names and relationships. _____

   Group counseling ☐ Please specify. _____

   Other ☐ Please specify. _____

6. Were any medications prescribed as a result of the crime? Yes ☐ No ☐

   If YES, please list the name of each medication and the purpose of the medication.

   _____

   _____

7. Was the client on any medications prior to the crime date? Yes ☐ No ☐

   If YES, please list the name of each medication and the purpose of the medication.

   _____

   _____

8. Diagnosis: (Please use DSM diagnostic codes and categories.)

Code	Category
_____:	_____
_____:	_____
_____:	_____

9. Check severity of client's dysfunction at this time

1	2	3		4	5	6		7	8	9
☐	☐	☐		☐	☐	☐		☐	☐	☐
	Mild				Moderate				Severe	

10. Describe the client's present symptoms, areas of dysfunction, and adaptive behavior in daily living. (including, but not limited to school performance and/or work activity, social functioning, and relationships with others)

_____

_____

_____

11. Describe any psychological tests administered, if any, and explain how the results of the testing relate to the need for treatment.

_____

_____

_____

12. Briefly describe your methods of treatment, including type, frequency, length of sessions, and projected duration.

_____

_____

_____

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With my signature, I declare and affirm under penalty of perjury, pursuant to O.C.G.A. § 17-15-11, that the information provided above in questions 1-12 is true and correct and that the expenses claimed herein are for remedial treatment of the victim for serious mental or emotional trauma directly related to the victimization. I understand that completion of this form only helps in the investigation of the claim, and that this does not guarantee that the Crime Victims Compensation Board will make payments for the services rendered. Please visit crimevictimscomp.ga.gov for the counseling benefits fee schedule.

_____ Date _____/_____/_____

Signature of Counselor/Therapist

_____ _____

License Number/Name of Board Phone Number