GEORGIA CRIME VICTIMS COMPENSATION PROGRAM
CRIMINAL JUSTICE COORDINATING COUNCIL
104 MARIETTA STREET, SUITE 440 ★ ATLANTA, GEORGIA 30303-2743
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SERIOUS MENTAL AND EMOTIONAL TRAUMA (SMET) VERIFICATION FORM

[For use only in Apalachee High School Applications]

The Criminal Justice Coordinating Council (CJCC) is the agency responsible for administering the State of Georgia's Crime Victim Compensation Program (CVCP). When a crime victim has submitted an application indicating that they suffered a serious mental or emotional trauma as a result of being threatened with a crime or being present during the commission of a violent crime, CJCC is required pursuant to O.C.G.A.§17-15-2 (9) to have supporting documentation from a licensed mental health professional. To assist the CVCP in determining eligibility, please complete and submit the information below.

Victim Name: _____

Victim DOB: _____

Date of Crime: September 4, 2024

1. In your professional opinion, did this client suffer a serious mental or emotional trauma as a result of being threatened with a crime or being present during the commission of a 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. Diagnosis (if available at this time):
   (Please use DSM diagnostic codes and categories.)

Code	Category
_____:	_____
_____:	_____
_____:	_____

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 1-3 is true and correct and that the information provided above is solely for assessment of the victim for serious mental or emotional trauma directly related to the victimization. I understand that completion of this form only helps reviewing eligibility of the claimant, and that this assessment does not guarantee an award of benefits. **If a claim is determined to be eligible, any payments beyond four sessions will require the completion of a Psychological Service Report before additional payments can be considered.** Please visit crimevictimscomp.ga.gov for the counseling benefits fee schedule.

_____ _____
Printed Name of Counselor/Therapist Signature of Counselor/Therapist

_____ _____ _____/_____/_____
License Number/Name of Board Phone Number Date