



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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.

GEORGIA CRIME VICTIMS COMPENSATION PROGRAM
CRIMINAL JUSTICE COORDINATING COUNCIL

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I, the undersigned, do hereby certify 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

Subscribed before me this ____ day of _____, _____

_____ My Commission expires _____, _____

Notary Public