



## GEORGIA CRIME VICTIMS COMPENSATION PROGRAM

104 Marietta Street, NW • Suite 440 • Atlanta, GA • 30303-2743  
404/657-2222 • 800/547-0060 • 404/463-7652 (Fax) • 404/463-7650 (TTY)

### Forensic Medical Examination Department of Family and Children Services Verification Form

For child sexual abuse/molestation allegations, a service provider has the option of submitting the Forensic Medical Examination Application for Payment or assisting the patient/family with submitting a Victims Compensation Application. If applying for the Forensic Medical Examination and there is limited collection and evaluation of evidence, please submit this Department of Family and Children Services Verification Form (DFCSVF) with the Application for Payment.

**Service Provider Instructions:** Please have the DFCS case manager, who requested the forensic medical examination, complete the following questions to assist us in determining if the child sexual abuse/molestation allegation (e.g. fondling, etc.) warranted a forensic medical examination to aid in the investigation. If you should have any questions regarding the completion of this form or about the Georgia Crime Victims Compensation Program, please call (404) 657-2222 or 1-800-547-0060.

Victim Information	Incident Information
Victim Name:	Date of Offense:

1. Based on the allegations of child sexual abuse/molestation (e.g. fondling, etc.), did you request a forensic medical examination for the victim named above? Yes\_\_\_ No\_\_\_
2. If **YES**, was the forensic medical examination necessary to your investigation? Yes \_\_\_No\_\_\_
3. If **YES**, was the victim in the custody of the state at the time of the sexual abuse/molestation? Yes \_\_\_No\_\_\_

**Please Note:** A payment request should not be submitted for a child who was in the custody of the state at the time of the sexual assault.

DFCS Official Name/Title: (Print) \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Ext.: \_\_\_\_\_

DFCS Official Signature: \_\_\_\_\_ Date: \_\_\_\_\_