NOTICE OF PUBLIC MEETING
ARIZONA SEX OFFENDER MANAGEMENT BOARD
JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

Pursuant to Arizona Revised Statutes (A.R.S.) § 38-431.02, notice is hereby given to the members of the **Arizona Sex Offender Management Board Juvenile Guidelines and Standards Subcommittee** (the "Subcommittee") and to the general public that the Subcommittee will hold a meeting, open to the public, on **November 12, 2026**.

The **November 12, 2026,** Subcommittee meeting will be a hybrid access meeting. This means that the public has the opportunity to participate in person or virtually. Information on how the public may attend is outlined below.

Please note the location of the **November 12, 2026,** Subcommittee meeting:

Thursday, November 12, 2026, 2026 1:30 p.m. – 3:30 p.m.
Arizona State Capitol
1700 West Washington Street (**Second Floor** Conference Room)
Phoenix, Arizona

Virtual Meeting Access, Microsoft Teams Meeting:
https://teams.microsoft.com/meet/290417397871328?p=CJFi6iKCu4R2lvl5bO
Meeting ID: 290 417 397 871 328
Passcode: Fa3fB3ow
Dial in by phone**: +1 480-536-7328,,315541770#**
Phone conference ID: 315 541 770#

The boardroom will be open to members of the public at 1:15 p.m.

A copy of the meeting agenda is attached. The Subcommittee reserves the right to change the order of items on the agenda.

Pursuant to A.R.S. § 38-431.02(H), the Subcommittee may discuss and take action concerning any matter listed on the agenda.

Pursuant to A.R.S. § 38-431.03(A)(2), the Subcommittee may vote to convene in executive session, which will not be open to the public, for discussion or consideration of records exempt by law from public inspection.

Pursuant to A.R.S. § 38-431.03(A)(3), the Subcommittee may vote to convene in executive session, which will not be open to the public, for legal consultation and advice concerning any item on the agenda.

Persons with a disability may request reasonable accommodation, such as a sign language interpreter, by contacting Ms. Ashlesha Naik at 602-223-2611 or via email at AZSOMB@AZDPS.GOV. Requests should be made as early as possible to allow time to arrange the accommodation(s).

DATED AND POSTED this 9th Day of November 2026.

By Jenna G. Mitchell
Major Jenna G. Mitchell
AZSOMB Program Manager

ARIZONA SEX OFFENDER MANAGEMENT BOARD
JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE
THURSDAY, NOVEMBER 12, 2026
Regular Session

1:30 PM

ALL ITEMS ON THIS AGENDA ARE OPEN FOR DISCUSSION AND POSSIBLE ACTION, INCLUDING REPORTS AND ACTION ITEMS.

THE AGENDA AND BACKGROUND MATERIAL ARE PROVIDED TO BOARD MEMBERS ELECTRONICALLY (WITH THE EXCEPTION OF MATERIAL RELATING TO POSSIBLE EXECUTIVE SESSIONS) AND POSTED ON THE ARIZONA PUBLIC MEETING WEBSITE AT https://publicmeetings.az.gov/. ADDITIONALLY, A HARD COPY OF THE AGENDA IS AVAILABLE AT 2222 WEST ENCANTO BLVD., PHOENIX, AZ. PLEASE EMAIL AZSOMB@AZDPS.GOV TO INSPECT THE DOCUMENTS.

REMINDER: As required by Open Meeting Law, please refrain from engaging in conversations, texts, emails and other forms of communication with individual board members. All questions, comments, deliberations and decisions should be stated to the public body as a whole in open session.

1. **ROLL CALL**

2. **MATTERS FOR DISCUSSION AND POSSIBLE ACTION**

   A. Old Business:
      i. Review of Revised Juvenile Guiding Principles (V10302026)
      ii. Discussion of Framework and Format for Psychosexual Evaluation Reports
         a. AOC Service Specifications for Psychosexual Evaluations – Presentation on the requirements for AOC contracted providers per the psychosexual evaluation service specifications – Mr. Steve Selover, Contracts and Monitoring Manager and Ms. Brooke O'Brien, Lead Contract Compliance Specialist
         b. Psychosexual Evaluations Overview – Presentation on the components of a juvenile psychosexual evaluation and the various ancillary assessments used in the process – Dr. David McGady, McGady and Associates Psychological Services and Dr. Alex Levitan, Levitan and Associates Psychological Services

   B. Call for Future Agenda Items (Deadline to Submit – December 2, 2026 @ Noon)

3. **THE SUBCOMMITTEE MAY VOTE TO CONVENE AND ENTER INTO AN EXECUTIVE SESSION FOR ANY REASON AUTHORIZED BY A.R.S. § 38-431.03,** including personnel matters, confidential records, legal advice, litigation, contract negotiations, employee salary discussions, and international or tribal negotiations. (To do so, the public body must first vote publicly to enter executive session, specifying the reason, and no legal action or final decisions can be made during the session. All motions and voting must be conducted after return to the public session.)

4. **ADJOURNMENT**

NEXT MEETING: December 10, 2026, 1:30 p.m. - 3:30 p.m.

BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

November 12, 2026

DRAFT JUVENILE GUIDING PRINCIPLES

V:10302026

Juvenile Guiding Principles

DRAFT 10/30/2026

Purpose of the Guiding Principles is to establish the core foundation principles from which the *Standards and Guidelines* are created and to provide guidance in the absence of a specific standard or guideline.

1. **The highest priority of the Juvenile Standards and Guidelines is to maximize community safety through the effective delivery of quality developmentally appropriate evaluation, assessment, treatment, and supervision of juveniles who engage in sexually abusive behaviors (sometimes referred to as Juveniles with Sexually Abusive Behaviors [JSAB]) (See Appendix).**

2. **Sexually abusive behaviors are traumatic and can have a devastating impact on the victim and victim's family.**

   Sexually abusive behavior can lead to common and serious consequences across all areas of victims' lives, including chronic and severe mental and physical health symptoms, as well as social, family, economic, and spiritual harm.[1] Research and clinical experience indicate that victims of sexually abusive behaviors often face long-term impact and continue to struggle for recovery over the course of their lifetime.[2] The impact of sexually abusive behavior varies based on numerous factors. By holding offenders accountable, victims may experience protection, support and recovery. Professionals working with juveniles should understand how a juvenile's behaviors may inflict further harm on persons they have previously victimized.[3]

3. **Community safety and the rights and interests of victims and their families require paramount attention when developing and implementing age appropriate assessment, treatment and supervision of juveniles who engage in sexually abusive behavior.[4]**

---

[1] Mason, F. & Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practice & Research Clinical Obstetrics and Gynaecology, 27*(1):27-37; Tjaden, P. & Thoennes, N. (2006). Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey. *Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice*; Walsh et al. (2012). National prevalence of posttraumatic stress disorder among sexually revictimized adolescent, college, and adult household-residing women. *Archives of General Psychiatry, 69*(9):935-942; Wilson, D. (2010). Health Consequences of Childhood Sexual Abuse. *Perspectives in Psychiatric Care. 46*(1): 56-64.

[2] Chen et al. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings, 85*(7):618-629.

[3] Feiring, C., & Taska, L. (2005). The Persistence of Shame Following Sexual Abuse: A Longitudinal Look at Risk and Recovery. *Child Maltreatment, 10*(4):337-349; Lodrick, Z. (2010). Victim guilt following experience of sexualized trauma: investigation and interview considerations. *The Investigative Interviewer, 1*:54–57; Patterson, D. (2010). The Linkage Between Secondary Victimization by Law Enforcement and Rape Case Outcomes. *Journal of Interpersonal Violence, 26*(2):328-347; Tamarit, J., Villacampa, C., and Filella, G. (2010). Secondary Victimization and Victim Assistance. *European Journal of Crime, Criminal Law and Criminal Justice, 18*(3):281-298.

[4] Briere & Scott (2006). Principles of trauma therapy: A guide to symptoms, evaluation, and treatment. Thousand Oaks, CA: Sage Publications; Morrison (2007). Caring about sexual assault: the effects of sexual assault on families, and the effects on victim/survivors of family responses to sexual assault. *Family Matters, 76*:55-63; O'Doherty, T., McLaughlin, S., Deirdre O'Leary, D. (2001). Recovery work with child victims of sexual abuse: A framework for intervention. *Child Care in Practice, 7*(1):78-88.

Community safety includes consideration of future potential victims who could be at risk of future harm, with the understanding that effective treatment, supervision, family engagement, and developmental supports are intended to promote safety and positive outcomes for all involved. In the event of a conflict, the Multi-disciplinary Team (MDT) (See Appendix) should be used to determine how to meet the needs of the juvenile in a manner that does not compromise community safety.

4. **Safety, protection, developmental growth, and the psychological well-being of victims are a priority for the MDT.**[5]

   Victims should have an opportunity to be heard and informed when decisions pertain to their safety. When feasible and requested, this should include the ability to provide input to the MDT.

5. **Treatment must address all types of abusive behaviors and not just the legally-defined delinquent behavior(s) for which they were adjudicated.**

6. **Treatment and supervision decisions should be informed by a comprehensive evaluation**[6] **and ongoing assessments.**[7]

   It is important to understand that risk assessment measures have limitations and that findings need to be used appropriately (i.e., within the scope of their empirically established limits). The evaluation and ongoing assessment of juveniles who have engaged in sexually abusive behaviors is a process. Ongoing assessment must constantly consider changes in the juvenile, family and community in order to make decisions concerning restrictions, supervision levels, placement, treatment and opportunities for positive growth and development of juveniles.

7. **Risk assessment of juveniles who have engaged in sexually abusive behaviors should be based on an empirically supported protocol.**[8]

DRAFT 10/30/2016

---

[5] Gootschall et al. (2015). Value, Challenges, and Solutions in Incorporating Victim Impact Awareness in Offender Rehabilitation - The Results of Qualitative Interviews with Stakeholders. *Victims & Offenders: An International Journal of Evidence-based Research, Policy, and Practice, 10*(3):293-317.

[6] Chu, M., & Thomas, S. (2010). Adolescent Sexual Offenders: The Relationship Between Typology and Recidivism. *Sexual Abuse: A Journal of Research and Treatment, 22*(2):218-233; Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. John Wiley & Sons; Ryan, G., Leversee, T. F., & Lane, S. (2010). Juvenile sexual offending: Causes, consequences, and correction, (3rd ed.). Wiley; Singh, J. P., Desmarais, S. L., Sellers, B. G., Hylton, T., Tirotti, M., & Van Dorn, R. A. (2014). From risk assessment to risk management: Matching interventions to adolescent offenders' strengths and vulnerabilities. *Children and Youth Services Review, 47* (Part 1), 1-9; Wijk, A. P., Mali, B. R., Bullens, R. A., & Vermeiren, R. R. (2007). Criminal Profiles of Violent Juvenile Sex and Violent Juvenile Non-Sex Offenders: An Explorative Longitudinal Study. *Journal of Interpersonal Violence, 22*(10), 1340-1355.

[7] Carpentier, J., & Proulx, J. (2011). Correlates of Recidivism Among Adolescents Who Have Sexually Offended. *Sexual Abuse: A Journal of Research and Treatment, 23*(4):434-455; Fanniff, A., & Becker, J. (2006). Developmental considerations in working with juvenile sexual offenders. In R. E. Longo & D. S. Prescott (Eds.), Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems (pp. 119-141). Holyoke, MA: NEARI Press; Hempel et al. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders
What is Next? *International Journal of Offender Therapy and Comparative Criminology, 57*(2):208-228; Oneal, B. J., Burns, L. G., Kahn, T. J., Rich, P., & Worling, J. R. (2008). The Treatment Progress Inventory for Adolescents who Sexually Abuse (TPI-ASA). Sexual Abuse: A Journal of Research and Treatment, 20(2), 161–187.

[8] Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. John Wiley & Sons; Ryan, G., Leversee, T. F., & Lane, S. (2010). Juvenile sexual offending: Causes, consequences, and correction, (3rd ed.). Wiley; Singh, J. P., Desmarais, S. L., Sellers, B. G., Hylton, T., Tirotti, M., & Van Dorn, R. A. (2014). From risk assessment to risk management: Matching interventions to adolescent offenders' strengths and vulnerabilities. *Children and Youth Services Review, 47* (Part 1), 1-9.

The risk assessment protocol, including the selection of instruments, should be tailored to the unique characteristics of the juvenile. A juvenile's level of risk should not be based solely on the sexually abusive behavior for which they are adjudicated. Other assessments designed to assess matters of general delinquency should also be considered.

8. **An MDT will be convened, and is responsible for post-disposition evaluation, treatment, care and supervision of juveniles who engage in sexually abusive behavior.**[9]

   The adoption of these standards and guidelines will support public safety outcomes when all agencies and parties are working cooperatively and collaboratively. Further, the Juvenile Court is an essential partner within the MDT framework and contributes to coordinated treatment, supervision, accountability, and rehabilitation efforts through judicial oversight and decision-making authority established by law. In Arizona, juvenile courts may utilize specialized court models and oversight practices that support treatment engagement, family involvement, community safety, and positive long-term outcomes for juveniles.

9. **Treatment and supervision decisions should be guided by current research and best practice.**

   Research with this population continues to emerge, which may lead to changes of these Guiding Principles. In the absence of research, decisions should be made cautiously and in accordance with best practices to minimize unintended consequences.

10. **Treatment and supervision should be individualized, developmentally appropriate, and responsive to the juvenile's assessed risks and needs.**[10]

    Juveniles who engage in sexually abusive behavior vary in ways such as; age, development, gender, culture, background, strengths, protective factors, and their presenting pattern(s) of sexually abusive behavior.

DRAFT 10/31/2025

[9] Center for Sex Offender Management (2007). Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners. *Center for Effective Public Policy, U.S. Department of Justice, Office of Justice Programs*, 2005-WP-BX-K179 and 2006-WP-BX-K004; Center for Juvenile Justice Reform (2012). Addressing the Needs of Multi-System Youth - Strengthening the Connection between Child Welfare and Juvenile Justice, Georgetown Public Policy Institute, Washington, D.C.; Lobanov-Rostovsky, C. & Hansen, J. (2013).

[10] Brogan, L., Haney-Caron, E., NeMoyer, A. & DeMatteo, D. (2015). Applying the risk-needs-responsivity (RNR) model to juvenile justice. *Criminal Justice Review, 40*(3):277-302; Carpentier, J., & Proulx, J. (2011). Correlates of Recidivism Among Adolescents Who Have Sexually Offended. *Sexual Abuse: A Journal of Research and Treatment, 23*(4):434-455; Hempel et al. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders: What is Next? *International Journal of Offender Therapy and Comparative Criminology, 57*(2):208-228; Hoge, R. D. (2016). Risk, need, and responsivity in juveniles. In K. Heilbrun (Ed.) APA Handbook of Psychology and Juvenile Justice (pp. 179-196). Washington D.C.: APA; Lipsey, M. W. (2009). The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview. *Victims and Offenders, 4*(2):124-147; Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. John Wiley & Sons; Ronis, S. & Borduin, C. (2007). Individual, Family, Peer, and Academic Characteristics of Male Juvenile Sexual Offenders, *Journal of Abnormal Child Psychology, 35*(2):153-163; Worling J. R. (2013). Desistence for adolescents who sexually harm (Unpublished document). Retrieved from http://www.erasor.org/new-protective-factors.html.

11. **Evaluation, ongoing assessment, treatment and supervision of juveniles who have engaged in sexually abusive behavior should be non-discriminatory, humane and bound by the law and applicable professional code of ethics.**[11]

    Professionals responsible for the evaluation, assessment, treatment, and supervision of juveniles who have engaged in sexually abusive behavior must not discriminate based on race, religion, gender, sexual orientation, disability or socio-economic status. Juveniles and their families shall be treated with dignity and respect by all members of the MDT.

12. **Assessment of treatment progress should be based on the juvenile's application of relevant changes in their daily functioning.**[12]

    Treatment should include measurable outcomes that will demonstrate progress and successful completion of treatment.

13. **Treatment should be holistic and enhance overall health and protective factors.**[13]

    Juveniles who engage in sexually abusive behavior may present other co-occurring issues and areas of risk. Research indicates that juveniles are at greater risk for non-sexual re-offenses than for sexual re-offenses.[14] Assessment and treatment plans should be comprehensive, trauma informed, and mitigate the risk of both sexually abusive behavior and other delinquent behavior while reinforcing developmental and environmental assets.

14. **Evaluation, assessment, treatment and supervision should be viewed through an ecological framework of Development.**[15]

    Assessment and intervention with a juvenile who has engaged in sexually abusive behavior recognizes the nature of adolescent development and the dependence on and influence by social-ecological factors, including family, peer group, community and school. This focus seeks to decrease risk factors and increase protective factors in the juvenile's ecology.

    The individualization of evaluations, assessment, treatment and supervision requires particular attention to social and cultural factors. Recognition of these factors are essential when interacting with clients from different social, cultural, and religious

DRAFT 11/30/2016

[11] Birgden, A. & Cucolo, H. (2011). The Treatment of Sex Offenders Evidence, Ethics, and Human Rights. *Sexual Abuse: A Journal of Research and Treatment, 23*(3):295-313.

[12] Hempel, I., Buck, N., Cima, M., Marle, H. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders: What is Next? *International Journal of Offender Therapy and Comparative Criminology, 57*(2):208-228.

[13] Leversee, T., & Powell, K. (2012). Beyond Risk Management to a More Holistic Model for Treating Sexually Abusive Youth. In B. K. Schwartz, The Sex Offender (Chapter 19). Kingston, NJ: Civic Research Institute.

[14] Caldwell, M. (2010). Study Characteristics and Recidivism Base Rates in Juvenile Sex Offender Recidivism. *International Journal of Offender Therapy and Comparative Criminology, 54*(2):197-209; McCann, K., & Lussier, P. (2008). Antisociality, Sexual Deviance, and Sexual Reoffending in Juvenile Sex Offenders. A Meta-Analytic Investigation. *Youth Violence and Juvenile Justice, 6*(4):363-385; Worling, J. R., & Langstrom, N. (2006). Risk of Sexual Recidivism in Adolescents Who Offend Sexually: Correlates and Assessment. In H. E. Barbaree & W. L. Marshall (Eds.),The Juvenile Sex Offender (2nd ed.) (pp. 219-247). New York: Guilford Press.

[15] Borduin et al. (2009). A Randomized Clinical Trial of MST with Juvenile Sexual Offenders: Effects on Youth Social Ecology and Criminal Activity, *Journal of Consulting and Clinical Psychology, 77*(1):26-37; Pullman et al. (2014). Examining the developmental trajectories of adolescent sexual offenders, *Child Abuse & Neglect, 38*(7):1249-1258.

backgrounds. A basic premise is to recognize the client's culture, your own culture, and how both affect the client-provider relationship. This premise extends to all professional members of the MDT and positive support persons and is essential in creating an equitable and inclusive environment, regardless of differences in culture or lifestyle.

15. **Family members/Primary Caregivers should be considered an integral part of evaluation, assessment, treatment and supervision.**[16]

    The families'/primary caregivers' abilities to provide informed supervision and support positive changes are critical to reducing risk of re-offense.

    Cooperative involvement with family members/primary caregivers enhances juvenile's prognosis in treatment. Family members/primary caregivers possess invaluable information about the juvenile who has engaged in sexually abusive behavior. Family members can be an important part of the juvenile's support system through the course of treatment and supervision.

    Conversely, non-cooperative family members may impede the juvenile's progress.[17] It is expected that the MDT will work with the family/primary caregiver to help them support the juvenile through cooperative involvement.

16. **Treatment and supervision decisions regarding juveniles who have engaged in sexually abusive behavior should minimize caregiver disruption and maximize exposure to positive peer and adult role models.**

    As juveniles move through the continuum of services emphasis should be given to maintaining positive and consistent relationships, including both in and out of a school setting. Research indicates that association with delinquent peers, the absence of pro-social adult role models, and the disruption of caregiver relationships increase the risk of delinquent development.[18]

17. **A continuum of care for treatment and supervision options should be available and utilized as needed.**[19]

---

16 Schroeder, R., Osgood, A., Oghia, M. (2010). Family Transitions and Juvenile Delinquency. *Sociological Inquiry, 80*(4):579-604; Spice, A., Viljoen, J., Latzman, N., Scalora, M., and Ullman, D. (2012). Risk and Protective Factors for Recidivism Among Juveniles Who Have Offended Sexually. *Sexual Abuse: A Journal of Research and Treatment, 25*(4):347–369; Thorton et al. (2008). Intrafamilial adolescent sex offenders: Family functioning and treatment, Journal of Family Studies, 14(2-3):362-375; Yoder et al. (2015). The Impact of Family Service Involvement on Treatment Completion and General Recidivism Among Male Youthful Sexual Offenders, *Journal of Offender Rehabilitation, 54*(4):256-277.

17 Baker, A., Tabacoff, R., Tornusciolo, G., Eisenstadt, M. (2003). Family Secrecy: A Comparative Study of Juvenile Sex Offenders and Youth with Conduct Disorders. *Family Process, 42*(1):105-116.

18 Burton, D. & Duty, K. & Leibowitz, G. (2011). Differences between sexually victimized and non-sexually victimized male adolescent sexual abusers: Developmental antecedents and behavioral comparisons. *Journal of Child Sexual Abuse, 20*(1):77-93; Miner & Munns (2005). Isolation and Normlessness - Attitudinal Comparisons of Adolescent Sex Offenders, Juvenile Offenders, and Nondelinquents, *International Journal of Offender Therapy and Comparative Criminology, 49*(5):491-504; Righthand, S. & Welch, C. (2004). Characteristics of youth who sexually offend. *Journal of Child Sexual Abuse, 13*(3-4):15-32.

19 Hunter, J. A., Gilbertson, S. A., Vedros, D., & Morton, M. (2004). Strengthening community based programming for juvenile sex offenders: Key concepts and paradigm shifts. *Child Maltreatment, 9*(2):177-189; Silovsky, J. F., Swisher, L. M., Widdifield Jr., J., & Burris, L. (2011). Clinical considerations when children have problematic sexual behavior. In P. Goodyear-Brown (Ed.). Handbook of child sexual abuse: Identification, assessment, and treatment. New Jersey: John Wiley & Sons.

DRAFT 10/30/2020

Decisions about level of care and supervision are informed by the youth's risk and need, taking into consideration the least restrictive environment while prioritizing community safety. Adjustments in the level of treatment and supervision should be made based on changes in risk and need, and continuity of services across these levels of care should be ensured. Whenever possible, priority should be given to the juveniles residing with their families or within the community in which their family resides.

18. **For juveniles who have been removed from the home family reunification can only occur after careful consideration of all the potential risks.**[20]

    The ability of parents to provide informed supervision in the home must be assessed in relation to the presenting risks of the juvenile. Reunification of the juvenile with the family should occur only after the parents/primary caregivers can demonstrate the ability to provide protection and support of the victim(s) and other children in the home, as well as address the needs and risks of the juvenile.

19. **Juveniles shall not be labeled as if their sexually abusive behavior defines them.**[21]

    It is imperative in understanding, treating and intervening with juveniles who engage in sexually abusive behavior to consider their sexual behavior in the context of the many formative aspects of their personal development. As juveniles grow and develop their behavior patterns and self-image constantly change. Research suggests that most juveniles will not go on to offend sexually as adults.[22] Not all juveniles who have engaged in sexually abusive behavior require extensive or intensive interventions in order to reduce their risk for reoffending because identity formation is a significant developmental task during adolescence, labeling juveniles based solely on sexual offending behavior may cause potential damage to long-term pro-social development.

20. **Successful completion of treatment and supervision depends upon a juvenile's willingness and ability to cooperate. Accordingly, members of the MDT should employ practices designed to maximize the juvenile's participation and accountability.**[23]

DRAFT 10/30/2020

---

[20] Hackett et al. (2014). Family Responses to Young People Who have Sexually Abused: Anger, Ambivalence and Acceptance, Children & Society, 28(2):128-139; Silovsky et al. (2011). Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes. Children and Youth Services Review, 33(8):1435-1444; Swisher, L., Silovsky, J., Stuart, R., & Pierce, K. (2008). Children with Sexual Behavior Problems. Juvenile and Family Court Journal, 59(4):49-69; Harper, B. (2012). Moving Families to Future Health: Reunification Experiences After Sibling Incest. Doctorate in Social Work (DSW), Dissertations. Paper 26; Price, D. (2004). Rebuilding Shattered Families: Disclosure, Clarification and Reunification of Sexual Abusers, Victims, and Their Families, Sexual Addiction & Compulsivity, 11(4):187-221.

[21] Miner et al. (2006). Standards of Care for Juvenile Sexual Offenders of the International Association for the Treatment of Sexual Offenders, Sexual Offender Treatment, 1(3); Schultz, C. (2014). The Stigmatization of Individuals Convicted of Sex Offenses: Labeling Theory and The Sex Offense Registry. *Themis: Research Journal of Justice Studies and Forensic Science*, 2(4):64-81.

[22] Carpentier, J., & Proulx, J. (2011). Correlates of Recidivism Among Adolescents Who Have Sexually Offended. Sexual Abuse: A Journal of Research and Treatment, 23(4):434-455; Fanniff, A., & Becker, J. (2006). Developmental considerations in working with juvenile sexual offenders. In R. E. Longo & D. S. Prescott (Eds.), Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems (pp. 119-141). Holyoke, MA: NEARI Press; Hempel et al. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders

What is Next? International Journal of Offender Therapy and Comparative Criminology, 57(2):208-228.

[23] Brogan, L., Haney-Caron, E., NeMoyer, A. & DeMatteo, D. (2015). Applying the risk-needs-responsivity (RNR) model to juvenile justice. Criminal Justice Review, 40(3):277-302; Englebrecht et al. (2008). "It's not my fault": Acceptance of responsibility as a component of engagement in juvenile residential treatment, Children and Youth Services Review, 30(4):466-484; Reicher (2013). Denying Denial in Children with Sexual Behavior Problems, Journal of Child Sexual Abuse, 22(1):32-51.

Appendix – Glossary Juvenile Guiding Principles

1. **Juveniles with Sexually Abusive Behaviors (JSAB)**— sometimes referred to as sexually maladaptive behavior (SMB) – encompasses a broad range of sexualized actions initiated by children and youth under age 18 that exceed typical, age-appropriate developmental exploration (such as standard curiosity or "playing doctor") and cause, or carry a significant risk of causing, harm to themselves or others.

   This population includes both adjudicated and non-adjudicated youth. Importantly, "sexual behavior problems" is a descriptive classification rather than a formal medical, psychological, or psychiatric diagnosis. The behavior exists along a wide continuum of severity, can be self-directed or directed toward others, and increasingly involves digital spaces, technology, and social media platforms.

   Age-Specific Distinctions & Terminology
   Clinical standards distinguish between younger children and older adolescents to ensure responses are developmentally appropriate and non-stigmatizing:

   - **Children Aged 12 and Younger (ATSA 2006 Standards):** Children aged 12 and under who initiate sexualized behaviors that fall outside acceptable societal limits or developmental expectations. Although the conduct is sexual in nature, underlying intentions are rarely purely sexual. Motivations frequently stem from developmental curiosity, anxiety, imitation of observed behaviors, attention-seeking, self-calming mechanisms, trauma responses, or sexual stimulation.
   - **Adolescents Aged 13 through 17 (ATSA 2017 Standards):** Professional guidelines specifically adopt person-first phrasing—**"adolescents who have engaged in sexually abusive behavior"**—over permanent labels like "juvenile sex offender." Research shows these behaviors are overwhelmingly transitory. Framing the conduct as a *past behavior* rather than a defining trait fosters an expectation of correction and growth for the youth, their family, and the community. Furthermore, descriptive terms provide critical clinical precision, distinguishing general sexual boundary violations from interpersonally abusive behaviors that directly harm others.

2. **Multidisciplinary Team (MDT)** is an integrated, collaborative group composed of the youth, their parents, caregivers, or legal guardians, and professionals across diverse disciplines—such as probation/parole officers, treatment providers, Department of Child Safety (DCS) caseworkers, behavioral health case manager, school personnel, and specialized clinicians. Formed following adjudication, deferred adjudication, or referral to probation, parole, outpatient services, or out-of-home placement (could include dependent/DCS involved youth), the MDT pools specialized expertise to evaluate, plan, and deliver a unified, highly coordinated response for justice-involved youth or wards of the state, including those with problematic sexual behaviors or developmental/intellectual needs.

   The team's primary purpose is to reach consensus on the specific type and intensity of care required. Because it is built directly around the youth, team membership adapts over time as individual needs evolve, with all members sharing mutual accountability for delivering coordinated evaluation, supervision, treatment, and ongoing support.

DRAFT 05/01/2026



BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

November 12, 2026

PSYCHOSEXUAL EVALUATION SERVICE SPECIFICATION (2024-2029)

PROVIDED

BY

MS.MELONY OPHEIM

Administrative Office of the Courts
Juvenile Justice Services Division
Contract Years 2024-2029
Psychosexual Evaluation Service Specification
Service Codes 118, 119, 122, 180, 310

PSYCHOSEXUAL EVALUATION, Service Codes 118, 119, 122, 180 & 310	
Category	Evaluation, Polygraph, and Laboratory Services (Form F-2)
Setting	• Professional office environment in a mental health center, detention, or private practice appropriate to the provision of evaluation, assessment, and treatment services.
Targeted Population	• Juveniles adjudicated by the Superior Court for a sexually abusive offense * or as ordered by the court. • Psychosexual evaluations are not for the purpose of determining sex offender registration status. *Pursuant to ARS §8-350.01(C), " 'sex offender' means a person who is twenty-one years of age or younger who is an adjudicated delinquent for or convicted of an offense that involves a violation of title 13, Chapter 14 and/or Chapter 35.1 and that does not involve the discharge, use or threatening exhibition of a deadly weapon or dangerous instrument."
Professional License	• Psychologists must be licensed by the Arizona Board of Psychologists Examiners under Arizona Revised Statues, Title 32, Chapter 19, and Articles 2 & 3. • Contractor must provide evaluation services only if it is within his/her scope of practice and has experience and training in normative sexual behavior in youth, adolescent development, in addition to juvenile-focused treatment/management /evaluation of issues related to sexually abusive behavior and general delinquency. • Contractor must remain current with changes and advancements in the profession, through collaboration and training related to psycho-sexual evaluation of adolescents. • Pursuant to §8-350.01(B)(1), "a mental health treatment program that a sex offender is required to participate in by a court, an adult or juvenile probation department, the state department of corrections or the department of juvenile corrections shall comply with the American Psychological Association (APA) professional code of ethics and the Association for Treatment of Sexual Abuser (ATSA) Juvenile Treatment Guidelines. • Use of psychometrists is outlined in Paragraph 37 (B)(C) of the AOC Standard Terms & Conditions for Full Procurement, and Paragraph 32 (A) AOC Standard Terms & Conditions for Independent Contractors.
Service Description	• **Psychosexual Evaluation:** This service includes a thorough and holistic psychological evaluation, the purpose of which is to assess and diagnose a juvenile's overall relevant cognitive and developmental, emotional, behavioral, trauma, and/or psychological conditions. The Primary purpose of this evaluation is to assess what contributed to the juvenile's current

offense, the overall risk factors, juvenile's criminogenic risk, needs and responsivity for, appropriate interventions and what can be done to facilitate healthy youth development.

- Psychosexual evaluations are not for the purpose of determining sex offender registration status.
- In addition, the service provides a sexual evaluation focused on the developmental and etiological factors related to sexual development and the development of sexually abusive behavior. This includes but is not limited to the range of sexual behaviors across the continuum from normative to atypical, abusive, and/or illegal; sources of sex education; consensual sexual experiences; sexual apprehension and confidence; exposure to sexual stimuli/use of pornography; sexual victimization; and fantasies accompanying the experience of arousal and behavior.
- Recommendations for treatment must not be limited to the juvenile's sexually abusive behaviors, but must be multi-dimensional, must address any victimization and/or trauma as reported by the juvenile, and must address the youth's general adjustment as well as other treatment and support needs identified by the juvenile and family. All recommendations for treatment or services must conform to the current Arizona Department of Health Services (ADHS) terminology for counseling and types of out of home care placements and/or Administrative Office of the Courts Levels of Care terminology.

- **Evaluation Addendum**: Within the ninety (90) days after the evaluation is completed, the evaluation addendum can be utilized for clarifications or a summary of additional information or test results which were not available at the time the evaluation was conducted. This service does not include client contact and does not require a formal report. New information or concerns are appropriately addressed by an Evaluation Update.
- **Evaluation Update**: This service includes a clinical interview and an updated review of records/information, including new information; may include additional testing; and is inclusive of a written evaluation update report, updating existing information that was cited in an evaluation prepared within the preceding ten (10) months. This report will make specific updated treatment recommendations, identifying significant changes or addressing further need for evaluation. The Contractor may request a comprehensive re-evaluation if it is determined an evaluation update alone will not adequately address the reason for referral. If more than ten (10) months has passed, another comprehensive Psychological Evaluation may be necessary to adequately address the reason for referral.
- **Professional Consultation:** Provide consultation service to the probation department and/or the court which can include developing and writing evaluation questions, court testimony or specific activities requested by the referring probation department. Professional Consultation is not case management.

Service Tasks	**Contract requirements set forth in the AOC Standard Terms & Conditions are applicable. Additionally:** 1. Review the Arizona Youth Assessment System (AZYAS) report provided by the referring probation department for integration into the evaluation. Document the delinquency risk level in the juvenile's evaluation report as reflected on the Service Authorization Form (SAF) and as determined by the probation department using the AZYAS full report. 2. Prior to evaluating the juvenile, participate in a professional consultation with the assigned JPO or designee to develop the referral questions to be answered through the psychosexual evaluation. This consult should also be utilized to determine if, due to the complexity of the case the evaluation may require additional time to complete. This may include dual wards with significant levels of trauma, significant mental health issues and developmental delays such as Autism Spectrum Disorder (ASD). Documentation is required for complex cases needing additional time for completion. 3. Psycho-sexual Evaluation must include review of referral material and information from the Probation Department, including the juvenile's school records, if applicable, information regarding the Juvenile's Individual Education Plan (IEP), previous assessments/evaluations, assessment of the individual's readiness for testing, development of an evaluation strategy and testing instruments to be used and formulation of recommendations for treatment. 4. Recommendations for specifics of court disposition must not be part of the treatment evaluation (i.e., sex offender registration, specific probation level of supervision [JIPS or Standard], recommendation for ADJC or detention, etc.). Instead, the recommendations should reflect the risk / needs, protective and promotive factors of the juvenile, reflecting the levels and intensity of treatment that are needed and how probation terms / interventions should match the identified risks and needs. 5. Conduct collateral interviews with the following parties, all attempts to conduct interviews must be documented and maintained in the client file including; a. Probation Officer: Through a professional consultation, talk to assigned JPO or designee to write the referral questions and discuss the nature of the current offense behavior; history of other delinquent behaviors or sexual offense issues to be assessed, including criminogenic risk, protective factors, and highlight present concerns impacting the juvenile, family, and identified victim(s); relevant records such as police reports, victim statements, and juvenile court history. b. Parent/Guardian: Obtain information regarding developmental history, relevant injuries, or medical history (including any prior hospitalizations, placement history, medical or developmental diagnoses and medications), family history, history of any trauma, dynamics and functioning of the juvenile and family, and parental reactions

to and impressions of the presenting problems, the needs of the juvenile and the caregiver's ability to meet the needs of the juvenile.

c. Interested Parties: Gather information from school personnel (to include copies of the most recent IEP, disciplinary reports, accomplishments, and positive school involvement, assigned case managers from other agencies (Department of Child Safety (DCS), Arizona Healthcare Cost Containment System (AHCCCS), Department of Developmental Disabilities (DDD), counselors and others, who have been or are currently involved directly with the juvenile and family.

6. Conduct one or more clinical interviews with the juvenile (only the licensed psychologist may conduct the clinical interview).
7. Evaluate the strengths of the juvenile and family, including community supports. Psycho-social assessment must include all of the following domains: Developmental history; history of trauma, including victimization; family and caregiver information; mental health history; delinquent / behavioral history; home environment; school/employment history and community; and must identify specific risk, needs and responsivity factors for the juvenile and family and an evaluation of any victimization reported by the juvenile (e.g. sexual victimization, domestic violence, physical abuse etc.).
8. Conduct relevant psychological / psychometric / psycho-educational testing, to measure cognitive and emotional processes, learning, and general level of functioning, including attitudes, intelligence, and/or emotional concerns. Assessment of cognitive and developmental functioning must be included unless such has been performed within the last year and is reviewed and results are documented as part of this evaluation. All testing should be used with validity to the assessment/procedural manual and be developmentally appropriate in addition to must be performed through standardized, validated, reliable, and non-abbreviated psychometric assessments. All psychometric assessments must be validated (normed for use with juvenile unless clinically appropriate) for use with adolescents for the youth's current age. Testing instruments for adults must not be utilized with a juvenile. If any tests are used which do not conform to these guidelines, the evaluator's report must provide the clinical justification for their use. All evaluations must include J-SOAP II (if applicable), IQ / cognitive testing, unless this has been done in the last year, and the results are reviewed and included in the current evaluation. As applicable, if diagnostic statements include formal DSM diagnoses, these must conform to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) terminology.
9. Evaluate the sexual history including normative sexual behaviors, illegal and abusive sexual behaviors and:
   a. Behaviors that are considered age and developmentally appropriate for adolescents.
   b. Abusive sexual behaviors (current or previous).

i. Types of abusive sexual behavior (e.g., hands on, hands off, illegal use of sexually explicit material, sexting).
ii. Victims' genders and ages, and relationship of the victim as well as number of persons sexually abused.
iv. Level of coercion or violence used or threats of violence before, during or afterwards, or level of gratuitous aggression.
v. Degree of invasiveness, (i.e., over the clothes, fondling, penetration).
vi. Degree to which the juvenile demonstrates responsibility for behavior(s) which occurred.

c. Patterns of offending:
i. Antecedents.
ii. Frequency.
iii. Duration / desistance.
iv. Escalation or de-escalation in frequency or severity; and.

d. Other problematic sexual behaviors including:
i. Preoccupation with sexual fantasies and behaviors.
ii. Excessive sexual activities such as compulsive masturbation.
iii. Frequent highly sexualized language.
iv. Frequent Sexualized gestures and behaviors, and
v. Persistent sexual interests involving significantly younger children, or coercion or force.

10. Provide an individualized written Psychosexual Evaluation Report to the referring Juvenile Court containing all of the following information, within fifteen (15) business days of the evaluation appointment, in accordance with the AOC Standard Terms & Conditions (only the licensed psychologist may write the report and provide interpretation of testing and assessment data). Record the dissemination of the report in the juvenile's file:

a. Referring Probation Department reason for referral.
b. Name and birthdate of the juvenile being evaluated.
c. Date, time, and location where the evaluation was conducted.
d. List of sources and specific records reviewed prior to the evaluation; these may include, but are not limited to prior psychological reports, IEPs, DDD evaluation, disposition reports, victim statements or police reports.
e. Summary of psycho-social information gathered from identified collateral sources, including probation, parents/guardians, school personnel, and/or other interested parties.

f. Name/credentials of person conducting testing and identification of testing instruments utilized. Include any rationale and determination of clinical appropriateness for utilizing.

g. Provide the psychological interpretation and diagnostic impressions; describe the risk / need profile for the juvenile; and discuss how the issues identified in Service Tasks 5-8 may impact the juvenile being evaluated and his/her problem sexual behaviors, including ability to participate in treatment. Treatment implications of existing medical, behavioral health and developmental diagnoses and medications must be considered (e.g., learning disabilities, Autism Spectrum Disorder, Down syndrome, Fetal Alcohol Syndrome, etc.).

h. If the diagnostic statements include formal DSM diagnoses, these must conform to the most current DSM terminology; there must be clearly identified supporting characteristics and symptoms specified in the report. Portions of the diagnosis based on historical data or information gathered should include the statement "by history".

i. Provide a statement of findings, conclusions and recommendations that respond to the referral questions developed with the Probation Officer, to the Court, in language or format that is easily understandable as follows:

i. Provide the psychological interpretation and diagnostic statements which specify the juvenile's issues (identified in Service Tasks 5-8); and discuss how these factors may impact the juvenile being evaluated, including history of trauma, developmental or learning disabilities or limitations.

ii. Considering the clinical interview, collateral information, testing, and information from all the domains assessed and protective and promotive factors identified, determine what factors may have contributed to the juvenile engaging in sexually abusive behaviors.

iii. Treatment recommendations should be informed by the bio-psycho-social and ecological model; treatment implications and limitations from existing medical and cognitive / developmental diagnoses and factors that are present currently and in the foreseeable future must also be considered.

iv. Make treatment recommendations and/or types of treatment interventions that match the juvenile's individual characteristics, learning style, cognitive, developmental, mental health, medical challenges, cultural norms, and identified gender and correspond with the findings without recommending a specific treatment provider or location. Treatment recommendations should match the juvenile's identified criminogenic risks, needs, and responsivity factors, including interventions to address any history of prior victimization and overall child well-being. Treatment recommendations must not be limited to addressing the juvenile's sexually abusive behaviors but must also address the juvenile's overall adjustment and other

identified issues and responsivity needs of the juvenile. The recommendations to the court must not include any referrals to the provider's own services. Treatment recommendations for counseling or out-of-home placement must utilize current ADHS terminology and / or the AOC Levels of Care terminology; if requested by the Court, recommendations may include general statements about matching the probation interventions to the risk / needs profile of the juvenile.

v. Describe the type(s) of care or services needed (i.e., substance use disorder, mental health, sexually abusive behavior services, trauma treatment, psychiatric services, specific educational support or interventions, interventions specific to criminogenic/risk needs responsivity model).

vi. Designate the least restrictive level of care (community-based, intensive outpatient, or out-of-home).

vii. Identify the intensity / frequency of care commensurate with the medical / psychological diagnoses and the overall behavioral health treatment needs of the juvenile.

viii. If recommending placement into out-of-home care, the Psychosexual Evaluation Report must provide the medical / psychological justification as to why the examiner does not feel that the juvenile can be adequately treated in an outpatient or intensive outpatient setting; recommendations for placement in out-of-home care settings are not to be based on risk to recidivate.

ix. The recommended treatment should involve family and/or other caregivers' input and information, unless contra-indicated.

x. Identify any need for other diagnostic assessments.

xi. Recommendations must include cultural considerations as applicable.

11. Provide testimony at court hearings if necessary.

REVIEW AND QUALITY ASSURANCE:
The AOC may periodically require the Contractor to participate in a peer review process to ensure that the Contractor is providing quality evaluations and maintaining acceptable service delivery.

PLEASE NOTE: For court order evaluations parental consent is best practice but not required. However, you are required to include a Minute Entry, Release Order, or a copy of the juveniles' Terms of Probation. A copy of the Minute Entry, Release Order or a copy of the juveniles' Terms of Probation shall be maintained in the juvenile 's file.

Professional Consultation	• Provide consultation service to the probation department and/or the court which has been authorized through a Service Authorization Form (SAF); billed in fifteen (15) minute increments under the appropriate service code; and billed only in conjunction with a contracted service. Consultation services can include developing and writing evaluation questions, providing court testimony or other specific activities requested in writing from the referring probation department. Professional Consultation is not case management. • The juvenile file must include a copy of a court's order or written directive for testimony or the probation department's written request for specific consultation. • Professional consultation must be documented in the juvenile file and must include a summary of consultation provided; location at which consultation occurred; persons participating in the consultation; date of consultation; duration of consultation; and name of person providing consultation. Consultation must not be provided in lieu of a contracted or non-contracted service. Professional consultation does not include emails and should occur either in person, phone, or a secured video platform.
Service Frequency	• Single service, as approved by a Service Authorization Form (SAF) or as court ordered.
Service Duration	• One unit equals one evaluation, addendum, or update. • Additional time for complex cases and the need for additional time must be clearly documented in the professional consultation.
Staffing	**STANDARDS/LICENSURE REQUIREMENTS:** • Psychologists must be licensed by the Arizona Board of Psychologists Examiners under Arizona Revised Statues, Title 32, Chapter 19, and Articles 2 & 3. • Psychometric testing may be performed by qualified Psychometrists, as outlined in the AOC Standard Terms & Conditions, Paragraph 37 (B)(C)(FP) & Paragraph 35 (C)(IP); psychometrists require AOC approval. • Only the licensed psychologist may conduct the clinical interviews, analyze, and interpret the results of the psychometric testing; make recommendations, and write reports. • Contractor may provide psycho-sexual evaluation services only if it is within his/her scope of practice. • Contractor must have experience and training in the field of sexually abusive behaviors, including training in J-SOAP-II. • Demonstrate specialized training and experience in forensic clinical practice and the ethical principles, standards of

	practice, and guidelines associated with forensic clinical work. • Demonstrate training and experience in the field of adolescent development, mental health, and juvenile justice. • Appropriate population experience, pursuant to AOC Standard Terms & Conditions, Section V, must have occurred within the preceding five (5) years of providing services under this contract.
Staff to Client Ratio	• One-to-one.
Hours of Operation	• Day, evening hours and may include weekends. • Hours of service should not conflict with the juvenile's academic day.
Desired Service Outcomes	• To provide a comprehensive evaluation describing the cognitive, developmental, emotional, behavioral, trauma, and/or educational needs of the juvenile and family; to assess behavioral health and emotional needs of the individual within the individual's cultural context. • To provide an evaluation of the juvenile's sexual history, specific victim profile, offense history, and risk (both sexual and general delinquency) to the community. • The report will make holistic treatment recommendations to address the juvenile's risk, needs, protective factors, well-being and identify the least restrictive level of care, which match the criminogenic risk / needs responsivity model for the juvenile evaluated. • Recommendations for placement will be commensurate with the juvenile's medical / psychological / behavioral health needs and will not be based on risk to recidivate. • Addendums and updates will provide supplemental or updated information related to the original report.
Unit of Service	• Psycho-sexual Evaluation, Evaluation Addendum, or Evaluation Update: One unit equals one Evaluation, Addendum, or Update and includes the written report for the Evaluation or Update. • Professional Consultation: One unit equals a 15-minute increment and only as authorized on SAF. • The need for additional time for evaluations of complex cases must be clearly documented in the professional consultation notes. Complex Cases with documentation will be compensated at an additional flat rate for psycho-sexual evaluations only.

Proposed Services & Rates:

Psychosexual Evaluation	Rate
AOC does not wish to pay more than the stated rate(s) below:	
Evaluation Addendum (sc 118)	**$188.00**/Addendum
Other Proposed Service Rate: Evaluation Addendum (sc 118)	$_____ / Addendum
Evaluation Update (sc 119)	**$581.00**/Update
Other Proposed Service Rate: Evaluation Update (sc 119)	$_____ / Update
Psychosexual Evaluation (sc 122) In-County	**$1,063.00**/Evaluation - 8 hours of clinical time and testing with youth, report, and case/record review
Other Proposed Service Rate: Psychosexual Evaluation (sc 122) In-County	$_____ / Evaluation additional hours needed after 8 hours billed in 15-minute increments
Psychosexual Evaluation (sc 122) Out of County	**$1,238.00**/Evaluation - 8 hours of clinical time and testing with youth and case/record review
Other Proposed Service Rate: Psychosexual Evaluation (sc 122) Out of County	$ _____ / Evaluation additional hours needed after 8 hours billed in 15 minute increments
Additional Rate: Complex Cases with documentation (310) added to in county and out of county rates	**$437.00**/.Evaluation
Other Proposed Service Rate: Complex Case (sc 310)	$ _____ / per Evaluation
Professional Consultation (sc 180)	**$44.00**/per 15 minutes (PhD)
Other Proposed Service Rate: Professional Consultation (sc 180)	$_____ / per 15 minutes (PhD)

Other agreement:

_____
_____
_____

All contracts and services must be in compliance with the AOC Standard Terms & Conditions, applicable service specifications & special contract conditions.

By signing below, I confirm that I have read and fully understand the requirements necessary to provide the Psychosexual Evaluation services, and I agree to all requirements, restrictions, service tasks, and contract rate(s):

_____

Contractor Signature / Date

AOC USE ONLY: DO NOT FILL IN BEYOND THIS LINE

Contracted Services & Rates:

Psychosexual Evaluation	Rate
Evaluation Addendum (sc 118)	**$188.00/**Addendum
Evaluation Update (sc 119)	**$581.00/**Update
Psychosexual Evaluation (sc 122) (In-County)	**$1,063.00**/Evaluation
Psychosexual Evaluation (sc 122) (Out-of-County)	**$1,238.00**/Evaluation
Additional Rate: Complex Cases with documentation (310) equals additional flat rate added to in county and out of county rates	**$437.00**/ per Evaluation
Professional Consultation (sc 180)	**$44.00**/per 15 minutes (PhD)

Other agreement (please list all counties you are willing to serve Out-of-County, if applicable):

_____
_____
_____

All contracts and services must be in compliance with the AOC Standard Terms & Conditions, applicable service specifications & special contract conditions.

By signing below, I confirm that I have read and fully understand the requirements necessary to provide the Psychosexual Evaluation services, and I agree to all requirements, restrictions, service tasks, and contract rate(s):

_____ _____

Contractor Signature / Date **AOC Signature / Date**