Pennsylvania Sexual Offenders Assessment Board
Application for Approved Treatment Provider Status

Please Type or Print

1. PROGRAM INFORMATION

Program/Individual Name:		
Legal Entity:		
Executive Director:		
Street or PO Box:	County:	
City:	State:	Zip Code:
Phone:	Cell:	
Fax:	Email (required):	
Professional PA Licensure:		
License Number:		
Additional Locations: Provide addresses, contact and treatment staff information for any additional locations on a separate sheet and attach as a part of this application.		

2. PROVIDER CREDENTIALS

a) Provide the **Name** of each staff member who will be providing sex offender treatment services:
b) Attach the **Curriculum Vitae** of each treatment staff member named above to this application.

c) Attach a copy of the professional **License** for each treatment staff member named above to this application. If the treatment staff member is unlicensed, indicate direct supervisor and attach a copy of the supervisory plan.

d) **Calculation of Professional Experience:** The Board requires the clinical supervisor of the treatment program to have a minimum of three years professional experience in treating sex offenders as well as a minimum of **2000** post-graduate supervised hours of face-to-face clinical contact. Complete a **Calculation of Professional Experience Form** for the clinical supervisor, as well as each treatment staff member.

e) **Specialized Training**: Each treatment staff member should list and attach certificates of participation/completion in specialized trainings in the field of sex offender treatment. This information should include the course name, the name of the person conducting the training, the name of the accrediting body sponsoring the training and the date of the training.

3. PROFESSIONAL CONDUCT

You may provide detailed explanations regarding any of the below inquiries on additional pages, if necessary.

a) Have you or any of your current staff ever been convicted of a felony? If yes, please explain.

b) Have you or any of your current staff ever been found to engage in unethical behavior by any licensing or certifying body? If yes, please explain.

c) Have you or any of your current staff ever had a license or certification revoked, canceled or suspended, or have you or any of your current staff ever been fined or placed on probationary status by any professional licensing body? If yes, please explain.

d) Have you or any of your current staff ever been found in violation of a licensing statute or regulation by a state licensing board? If yes, please explain.

e) Do you or any of your current staff have any pending professional liability or malpractice actions or final judgments involving your professional practice? If yes, please explain.

4. REFERENCES

List three references who are familiar with your professional qualifications. Please include name, mailing address, email address, and phone number for each reference.

5. PROGRAM REQUIREMENTS

a) **Treatment Program Information:** Attach a detailed summary describing your sex offender treatment program, including, but not limited to, the types of services offered or required, the program design, therapeutic approach, treatment philosophy and treatment modality. In addition, attach copies of your program's policies and procedures, as well as any program materials (such as manuals and/or assignment worksheets).

b) **Program Demographics:** Attach a detailed summary describing your program's treatment setting, the hours of operation, the number of sexual offenders treated, the caseloads of the treatment staff members, and the overall treatment capacity.

c) **Consent to Treatment**: Prior to enrollment, Sexually Violent Predators shall be informed, in writing, of the statutory requirements related to participation in treatment and the potential consequences of noncompliance. Attach a copy of your program's Informed Consent.

d) **Assessments:** Sexually Violent Predators shall have a **comprehensive formal assessment** at the onset of treatment, in order to establish an individualized treatment plan, as well as **annual progress updates.** Attach a template of your program's assessment reports**.**

e) **Individual Treatment Plan:** Programs are required to employ written Individual Treatment Plans (ITP) for each offender. ITPs shall be specifically tailored to the individual offender and contain measurable goals, objectives and treatment interventions. Attach a template of your program's ITP.

f) **Communication with Other Involved Agencies:** Each program must provide written reports of an offender's progress to the responsible criminal justice, correctional and probation or parole authorities at least once every six months. Attach a template of your program's related documents.

g) **Polygraph:** Each program must have the capacity to provide for the administration of sex offender specific clinical polygraph testing. Polygraph testing shall be provided annually, at a minimum, and shall be performed in collaboration with the criminal justice agency providing supervision. Attach the name, contact information, credentials and a copy of the contract (if applicable) with the polygrapher associated with your program**.**

h) **Objective Measures of Sexual Interest:** Each program must have the capacity to provide for the administration of objective measures of sexual interest, such as the Affinity or the Abel Assessment for Sexual Interest (AASI). Attach the name, contact information, credentials and a copy of the contract (if applicable) with the individual who will be providing these services for your program.

i) **Medical Evaluation / Pharmacological Therapies:** Each program must have the capacity to provide or arrange for medical evaluation and prescription of pharmacological therapies. Attach the name, contact information, credentials and a copy of the contract (if applicable) with the physician who will be providing these services for your program. It is preferable that the associated physician have experience treating sexual offenders.

j) **Ancillary Services:** Provide information regarding the availability of referrals to specialized ancillary services for sex offenders who display special needs or co-occurring disorders.

By my signature below:

- I affirm that I have thoroughly reviewed the Sexual Offenders Assessment Board approved Treatment Provider Standards.
- I state that the answers provided in the foregoing application are true and correct upon my personal knowledge or information and belief. This statement is made subject to the penalties of 18 Pa. C.S. §4904 relating to unsworn falsification to authorities.
- I also understand that if any answer given in the foregoing application is subsequently discovered to be false, the Sexual Offenders Assessment Board has the absolute right to revoke this applicant's approval as an approved treatment provider as set forth in 42 Pa. C.S. §9799.36.

Signature: **Date:**

Please sign and attach the Statement of Understanding.

Please mail or fax the completed Application and necessary attachments to:

Pennsylvania Sexual Offenders Assessment Board
1101 South Front Street, Suite 5700
Harrisburg, PA 17104
Fax: (717) 705 – 2618

STATEMENT OF UNDERSTANDING

I have submitted all requested information for the purpose of being certified by the Pennsylvania Sexual Offenders Assessment Board as an approved Treatment Provider for Sexually Violent Predators (as determined by the Courts).

I have read the Treatment Standards developed by the Sexual Offenders Assessment Board and agree that my treatment program is designed to comply with these standards.

I agree to notify the Sexual Offenders Assessment Board of changes to my program that may affect compliance.

Director of Program (Please Type or Print)

Signature of Director of Program

Date

CALCULATION OF PROFESSIONAL EXPERIENCE

Complete this form for all counselors providing treatment services. Include as many pages of this form as needed.

Professional Experience (List most recent first)

Employer

Employer Address

Job Title | Dates of Employment (inclusive)

Total number of hours with sexual offenders:
Research (total, not per week) _____
Direct Assessment _____
Treatment _____
Total: _____

Employer

Employer Address

Job Title | Dates of Employment (inclusive)

Total number of hours with sexual offenders:
Research (total, not per week) _____
Direct Assessment _____
Treatment _____
Total: _____

Employer

Employer Address

Job Title | Dates of Employment (inclusive)

Total number of hours with sexual offenders:
Research (total, not per week) _____
Direct Assessment _____
Treatment _____
Total: _____

Grand Total of hours in research, direct assessment and/or treatment of sexual offenders: _____