

CONFIDENTIAL
REQUEST FOR PAE: PRE-AUTHORIZED EXPENSE (ORS 135.055(3))
PSYCHO-SEXUAL EVALUATION SHORT FORM

<input type="checkbox"/> Retained	<input type="checkbox"/> Appointed
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County: _____ Case Type: _____ Case Number: _____

Client's First Name: _____ Client's Last Name: _____

Attorney Name: _____ Bar #: _____ Email: _____

Provider's Name: _____ Business Name: _____

Provider's City: _____ Phone: _____

****If assigned to more than one case for a client, select case number with the highest charge. This form may only be used once****

Number of hours requested: _____ *If additional hours are needed, please use the long form and include justification.*

Is the evaluator providing bilingual services for this evaluation? Yes No

Provider agrees to work at their OPDC established rate

If not, please use the long form and include justification. If this is a new provider that does not have an OPDC established rate please use the long form and include a CV.

Do you believe your representation of this client requires you to obtain a Psycho-Sexual evaluation? Yes No

Attorney certifies that the following applies (please check all that apply):

- Client is charged with a sex offense
If not, please use the long form and provide justification as to why this evaluation is reasonable and necessary
- This is the first request for a Psycho-Sexual Evaluation
If this is not the first request or if this is a request for additional hours, please use the long form.
- This evaluation is requested pursuant to ORS 163A.030

Are you requesting any travel expenses? Yes No	
DEPARTING FROM: _____	ARRIVING AT: _____
MILEAGE - ESTIMATED NUMBER OF MILES: _____	TRAVEL TIME - HOURS: _____

I am the attorney representing the client named on this form. I have reviewed and approve this submission.

PLEASE NOTE: Services/expenses prior to the effective date will not be paid.

Signature of Attorney*

Submission/Effective Date

*Electronic signature is valid. There is no need to print and sign this document.