

COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD (DVOMB)

2017 BIENNIAL RENEWAL FORM

All Domestic Violence Management Board Approved Treatment Providers (including those who are "Not Currently Practicing") are required to renew their placement on the Approved Provider List biennially.



*Please PRINT LEGIBLY and submit all required materials prior to the **July 31, 2017** deadline to:*

**Colorado Department of Public Safety
Division of Criminal Justice
DVOMB**

700 Kipling Street, Suite 3000, Denver, CO 80215

<http://dcj.dvomb.state.co.us/>

303-239-4528 or 303-239-4536

You may submit your renewal packet electronically to:

carolina.thomasson@state.co.us



COLORADO
Department of Public Safety

Who Should Complete this Application?

All DVOMB approved providers regardless of approval date, including those who are not practicing, who are RENEWING their listing with the DVOMB in order to continue providing services to court ordered domestic violence offenders. * Providers should renew as individuals, not partnerships or programs.

How to Complete this Application

Please read all of the application in its entirety. It is updated and changed every renewal period.

- Please read all of the application in its entirety. It is updated and changed annually.
- The applicant should request assistance from a clinical supervisor in completing this application, if applicable.
- Within the body of this application, you will be asked to attest to your compliance with training and clinical experience according to very specific sections of the Standards. The applicant should first read and understand the Standards before completing this application. Within the body of this application, you will be asked to document your training; you may wish to compile these materials in advance.
- When complete, you should return a single-sided hard copy of the application with supplemental information to the address on the cover page, "Attention: DVOMB". Save a copy of the completed application, including attached documents for your files.
- Additional copies of the Standards or the application materials may be obtained by contacting (303) 239-4536. Standards are also available at <http://dcj.somb.state.co.us/>
- Questions may be addressed to the Standards Coordinator at (303) 239-4536 for questions pertaining to this application.
- Standards compliance will be assessed over time through a periodic renewal process (every two years), a monitoring process, and a mechanism to receive and investigate complaints within the policies established for such complaints and via Quality Assurance Reviews according to the DVOMB policy and procedure.

General Instructions

Your adherence to the instructions throughout the application will help ensure that your application is not returned to you by the Domestic Violence Offender Management Board staff or otherwise delayed.

1. Follow all instructions carefully.
2. Use the forms provided in this packet.
3. Submit ONLY information requested, in the order requested.
4. Keep a copy of your completed application and attachments for your files.
5. All providers wishing to renew their DVOMB approval must submit a **\$200 MONEY ORDER OR CERTIFIED CHECK** payable to the "Colorado Department of Public Safety." No cash or personal checks will be accepted. ***If you are a new provider approved on or after August 1, 2016, you are exempt from this fee, however must submit this completed form.*** The fee is **NON-REFUNDABLE.**
6. Please complete and submit the enclosed "**Contact Information Update Form.**" You may list up to a maximum of four addresses for listing. If you are "Not Currently Practicing" you are exempt from providing supervisor/peer consultant information and DV Treatment Advocate information, yet you must provide updated contact information.

APPLICANT NAME: _____

DATE: _____ **Provider #:** _____

(DVOMB use only)

For Continued placement on the Domestic Violence Offender Management Board Approved Provider List.

Please answer the following questions:

1. Are your practices in compliance with the *Standards for Treatment with Court Ordered Domestic Violence Offenders (Standards)*?

YES YES, AND I HAVE A VARIANCE FOR SECTION _____ NO

If no, you must attach a written explanation that includes whether why you are not in compliance with the *Standards*.

2. Since your last renewal have you been disciplined and/or found to engage in unethical behavior by any licensing or certifying body or professional organization? If yes, please attach an explanation.

YES NO

3. Since your last renewal have you had a license or certification revoked, suspended, renewal refused, or been placed on probationary status by any professional licensing body? (This includes any currently pending challenge to your licensure, certification or registration.) If yes, please attach an explanation.

YES NO

4. Since your last renewal have you voluntarily relinquished a license or certification to provide psychotherapy, or voluntarily or involuntarily terminated any mental health staff privileges? If yes, please attach an explanation.

YES NO

5. Since your last renewal have you been arrested, charged, convicted, received a deferred judgment for, or pled nolo contendere for any criminal offense? If yes, please attach an explanation.

YES NO

DV Clinical Supervisor or Peer Consultant

NA – Not Currently Practicing.

Your Domestic Violence Clinical Supervisor or Peer Consultant must complete the following page and sign.

DV CLINICAL SUPERVISOR

PEER CONSULTANT

Name: _____

Address: _____

Email: _____

Phone(s): _____

Mode of contact: In person;

Electronic modes of contact: Telephone; Email; Video chat (skype, Facetime, etc).

If electronic modes of supervision or peer consultation are utilized, has face-to face supervision or consultation occurred on no less than on a quarterly basis?

YES NO; If no, please explain _____

Signature of Supervisor or Peer Consultant: _____

Continuing Education

TREATMENT PROVIDER: Please complete the chart below by filling in the continuing education hours (CEU's) you accrued between July 31, 2015 and July 31, 2017.

YOU ARE EXEMPTED FROM CEU'S IF YOU ARE A NEW PROVIDER APPROVED ON OR AFTER AUGUST 1, 2016.

If this applies to you, please initial here: _____

SPONSORING AGENCY	TITLE OF COURSE, PROGRAM, ETC.	DATE	HOURS EARNED
TOTAL HOURS :			

PLEASE DO NOT SUBMIT COPIES OF YOUR CERTIFICATES AT THIS TIME. IN THE EVENT OF A QUALITY ASSURANCE REVIEW OR COMPLAINT, YOU WILL BE REQUESTED TO SUBMIT CERTIFICATES.

Treatment Victim Advocate Information

NA – DV Provider is Currently Not Practicing.

Your DV Treatment Victim Advocate must complete pages 7 & 8: (IF YOU USE MORE THAN ONE TREATMENT VICTIM ADVOCATE, PLEASE HAVE EACH TREATMENT VICTIM ADVOCATE FILL THIS SECTION SEPARATELY AND SIGN).

To the best of your knowledge, is the domestic violence approved provider whom you provide Treatment Victim Advocate services to, in compliance with section 7.0 of the *Standards for Treatment with Court Ordered Domestic Violence Offenders (Standards)*?

YES NO

If no, you must attach a written explanation that includes an explanation of non-compliance with the *Standards*.

Name of TVA: _____

Address: _____

Email: _____

Phone(s): _____

Please answer the following questions:

What other volunteer or paid work you do outside of the agency? _____

Do you have any other roles in the agency where you are a TVA? YES NO; **If**

yes, please explain: _____

Are you involved in the MTT decision-making for the treatment and supervision of DV offenders?

YES NO; **Comments:** _____

Mode of contact with MTT: In person Telephone Email Video chat
(skype, Facetime, etc).

Current Treatment Victim Advocate Level: Entry Fully Qualified

**ENTRY Level Treatment Victim Advocate:
Training Hours**

Please list the 30 hours of training you have completed to meet the Entry Level requirements per Section 7.0

Training hours that are older than 5 years will not be accepted. Please submit certificates.

<u>Sponsoring Agency</u>	<u>Title of Course, Program, ETC.</u>	<u>Date</u>	<u>Hours Earned</u>

ENTRY Level Experiential Hours

Please include documentation regarding 70 hours of experiential work (may be documented by: letter from Domestic Violence Offender Provider, timesheets or invoices, internship supervisor letter, etc).

FULLY QUALIFIED Treatment Victim Advocate

Please include COVA or NOVA Certificate

Signature of TVA: _____

Attestation

Please initial your current approval status:

_____ **Provisional Level** - By signing below, I verify that I have completed my 14 hours of continuing education as per the *Standards, Section 9.0*. I confirm that all the information contained in this Renewal Form is true. (Of the 14 hours, at least 7 shall be on victim issues and the balance on training requirements for Full Operating Level approval). I hereby attest I will maintain compliance with the *Standards* throughout this next renewal cycle. If I find difficulty maintaining compliance, I will refer to the Variance Process (*Standards, Section 11.17*), and seek guidance from DVOMB Staff.

_____ **Entry Level** - By signing below, I verify that I have completed my 14 hours of continuing education as per the *Standards, Section 9.0*. I confirm that all the information contained in this Renewal Form is true. (Of the 14 hours, at least 7 shall be on victim issues and the balance on training requirements for Full Operating Level approval). I hereby attest I will maintain compliance with the *Standards* throughout this next renewal cycle. If I find difficulty maintaining compliance, I will refer to the Variance Process (*Standards, Section 11.17*), and seek guidance from DVOMB Staff.

_____ **Full Operating Level** - By signing below, I verify that I have completed my 28 hours of continuing education as per the *Standards, Section 9.0*. I confirm that all the information contained in this Renewal Form is true. (28 hours every 2 years in topic areas relevant to improved treatment with court ordered domestic violence offenders. Of the 28 hours, diversity and victim issues shall be included). I hereby attest I will maintain compliance with the *Standards* throughout this next renewal cycle. If I find difficulty maintaining compliance, I will refer to the Variance Process (*Standards, Section 11.17*), and seek guidance from DVOMB Staff.

_____ **DV Clinical Supervisor Level** – By signing below, I verify that I have completed my 28 hours of continuing education as per the *Standards, Section 9.0*. I confirm that all the information contained in this Renewal Form is true. (28 hours every 2 years in topic areas relevant to improved treatment with court ordered domestic violence offenders. Of the 28 hours, diversity and victim issues shall be included). I hereby attest I will maintain compliance with the *Standards* throughout this next renewal cycle. If I find difficulty maintaining compliance, I will refer to the Variance Process (*Standards, Section 11.17*), and seek guidance from DVOMB Staff.

DVOMB Approved Treatment Provider's Signature

Date

March 2017

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CONTACT INFORMATION UPDATE

TREATMENT PROVIDER: The below information is requested for the purpose of revising the *DVOMB APPROVED PROVIDER LIST*. Providers may be listed up to a maximum of **four** times. Please type or PRINT LEGIBLY.

Treatment Provider Name: _____

What are your DORA credentials (*CAC III, LPC, etc.*)? _____

Cell phone #: _____

E-mail: _____

Please list languages (other than English) in which you provide DV treatment. _____

I have reviewed the contact information on the Provider List, and no updates are required at this time.

Please list for #1 AGENCY (below) your **PRIMARY** mailing address:

#1 AGENCY:

Mailing Address:

City County Zip

Phone Number: _____ Fax Number: _____

Judicial District # _____

The mailing address I have listed above is my **home** address and should not be posted on the Approved Provider List.

Please list up to three **other** offices where you provide dv treatment:

#2 AGENCY:

Address:

City County Zip

Phone Number: _____ Fax Number: _____

Judicial District # _____

#3 AGENCY:

Address:

City

County

Zip

Phone Number: _____ Fax Number: _____

Judicial District # _____

#4 AGENCY:

Address:

City

County

Zip

Phone Number: _____ Fax Number: _____

Judicial District # _____

Thank you for the valuable work you do!