

**Colorado Sex Offender
Management Board (SOMB)**

**APPLICATION 1
First Application
for Associate Level**

**for Placement on the
Adult and/or Juvenile Provider List**

Treatment Provider and/or Evaluator



**Colorado Department of Public Safety
Division of Criminal Justice
Office of the Sex Offender Management Board
700 Kipling Street, Suite 3000, Denver, CO 80215**

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

Telephone: (303) 239-4526 or 4199 | Fax: (303).239.4491



COLORADO
Department of Public Safety

What Application Should I Be Using?

Application 1 – First Application for Associate Level

This application is used when a provider is applying to SOMB for the first time for a 12-month initial listing. Application 1 is also used when adding on to your listing (e.g. adding DD Specialty or Evaluator status).

Application 2 – Initial Three Year Associate and/or Change of Status Application

Application 2 is used when a provider has completed Application 1, completed an initial 12-month listing and is now applying to be listed at the Associate or Full Operating Level for the next three (3) years.

Application 2 is also used anytime you are changing your status (e.g. moving from Associate Level to Full Operating Level).

Application 3 – Renewal of Current Listing as Associate Level, Full Operating Level and/or Clinical Supervisor

This application is used when a provider has completed Application 2, completed a three (3) year listing, and is renewing their current status for the next three (3) year renewal period.

Who Should Complete this Application?

Individuals who wish to apply for Associate Level on the Sex Offender Management Board's approved provider list(s) shall submit this application to the Board pursuant to:

1. Section 4.100 of the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders*, published by the Sex Offender Management Board, revised November 2011, and Section 4.100 of the *Standards and Guidelines for the Evaluation, Assessment, Treatment, and Supervision of Juveniles Who Have Committed Sexual Offenses*, revised December 2014.
2. The Competency-Based Provider Approval Model in Appendices of both the Adult and Juvenile Standards.

Please note: This listing is only valid for twelve (12) months. Any provider wishing to **add** onto their current status **shall** provide Application 1 (e.g. a treatment provider working towards becoming an evaluator, etc.). You will receive a letter from the Sex Offender Management Board staff indicating that your paperwork has been processed, and your name will subsequently be published on the provider list on the Sex Offender Management Board website. If you have more than one supervisor, please fill out a box for each. *Applicants should apply as individuals, not partnerships or programs.

Polygraph examiners should not submit this form. Please see Polygraph Examiner applications.

How to Complete this Application

- **Please read all of the application in its entirety.** It is updated and changed annually.
- The applicant should request assistance from his/her clinical supervisor in completing this application.
- 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: SOMB". 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) 239-4526. *Standards* are also available at <http://dcj.somb.state.co.us/>
- Questions may be addressed to the Adult Standards Coordinator at (303) 239-4499 for questions pertaining to the adult portion of this application, and to the Juvenile Standards Coordinator at (303) 239-4197 for questions pertaining to the juvenile portion of this application.
- Standards compliance will be assessed over time through a periodic renewal process (every three years), a monitoring process, and a mechanism to receive and investigate complaints within the policies established for such complaints and via Standards Compliance Reviews according to the SOMB 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 Sex Offender Management Board staff or otherwise delayed.

1. Follow all instructions carefully.
2. Use the forms provided in this application.
3. Submit ONLY the information requested.
4. Submit the required information in the order requested.
5. Keep a copy of your completed application and attachments for your files.
6. **PLEASE DO NOT** use staples, paper clips, binders, sheet protectors or other materials because all applications are copied multiple times in their entirety during processing.
7. Please submit all materials on **SINGLE-SIDED COPIES**.

Please submit this application with a SOMB Fingerprint Card.
Cards can be obtained by calling (303) 239-4199

Compliance with the Standards will be assessed over time through a periodic renewal process, a monitoring process, and a mechanism to receive and investigate complaints within the policies established for such complaints.

Application for Placement on the Sex Offender Management Board's Provider List

Applicant Name: _____ Date: _____
Credentials (MA, LCSW, etc.): _____

Home Address: (Street, City, State and Zip Code): _____
Home Telephone Number: _____
Home Email: _____

Please note that the home address is considered CONFIDENTIAL and will only be used if the staff is unable to locate you through your employer. Employer or Business name, address, phone, fax, and email information is used for the approved provider list.

Agency: _____
Agency Address (Street, City, State and Zip Code): _____

Agency Telephone Number: _____
Business Email: _____
County of Primary Location: _____

Supervisor's Name: _____
Agency: _____
Agency Address (Street, City, State and Zip Code): _____

Agency Telephone #: _____
Email: _____

Supervisor's Name: _____
Agency: _____
Agency Address (Street, City, State and Zip Code): _____

Agency Telephone #: _____
Email: _____

Associate Level Contract

I understand this contract is valid for 12 months. I will be able to submit my Application 2 for approval to the Board within **one year** from the date indicated on this contract.

I have read and understand the Competency-Based Treatment Provider, Evaluator Approval Model (Appendices of both the Adult and Juvenile Standards).

Please check all levels and/or specialties that you are applying for.

- | | |
|--|---|
| <input type="checkbox"/> Adult Associate Level Treatment Provider | <input type="checkbox"/> Juvenile Associate Level Treatment Provider |
| <input type="checkbox"/> Adult Associate Level Evaluator | <input type="checkbox"/> Juvenile Associate Level Evaluator |
| <input type="checkbox"/> Adult Developmental Disability Specialty | <input type="checkbox"/> Juvenile Developmental Disability Specialty |

For applicants who have a criminal history, please enclose with this contract a written explanation of the charges, and verification of the disposition. Please note that it is illegal to practice psychotherapy in the state of Colorado without registration or licensure through D.O.R.A. (Department of Regulatory Agencies) unless you work for an exempt agency. Please contact D.O.R.A. for details.

I understand that I must accumulate specialized training, and other requirements prescribed in the Competency-Based Provider Approval Model. Clinical supervision and training will be assessed through an individualized comprehensive supervision plan. The Application Review Committee may request a copy for review.

My clinical supervisor and I are in agreement that supervision will be governed by the requirements prescribed in the Competency-Based Provider Approval Model.

Please note: Any clinical supervision ***shall not*** be provided by a relative of the applicant.

I am enclosing:

- ☐ A completed **fingerprint card**.
- ☐ Documentation/verification of my status with D.O.R.A. (i.e., copy of registration or licensure).
- ☐ A **money order** made out to “**CBI**” for **\$39.50**.
- ☐ This signed application entitled “**Application 1 -First Application for Associate Level**”.
- ☐ Competency rating from your clinical supervisor

Professional Supervision Agreement for Associate Level Treatment Providers or Evaluators: *Adult and Juvenile Applicants*

I understand that _____ is practicing under my licensure and SOMB listing status, and that I am responsible for their clinical supervision. I have developed an individualized comprehensive supervision plan for _____ in accordance with the Competency-Based Provider Approval Model and will have it available for the Application Review Committee upon request.

If any of your personal or professional information changes, you must report the information to the SOMB within two weeks.

Supervisor's Name (Please Print Clearly) _____

Supervisor's signature: _____ **Date:** _____

Applicant's Name (Please Print Clearly) _____

Applicant's signature: _____ **Date:** _____

Statement of Understanding

1. I understand that the information I have submitted on this application for the Sex Offender Management Board Provider List will be used for the following purposes:
 - A. To conduct criminal history checks and background investigations as necessary.
 - B. To create and disseminate a provider list of treatment providers, evaluators, and/or polygraph examiners.
2. My application materials will become a public record of the Division of Criminal Justice and may be subject to open record act requests pursuant to Section 24-72-304, C.R.S.
3. Inclusion on the provider list does not constitute certification or licensure and should not be represented as such. It does not create an entitlement or guarantee that I will receive referrals. If I am approved to be on the Provider List, it means that I am eligible to be considered as a provider of evaluation, assessment, treatment, and/or behavioral monitoring services for convicted sex offenders and/or adjudicated juveniles who have committed a sexual offense, pursuant to Section 16-11.7-106, C.R.S. which states:

“(1) The department of corrections, the judicial department, the division of criminal justice of the department of public safety, or the department of human services shall not employ or contract with and shall not allow a sex offender to employ or contract with any individual or entity to provide sex offender evaluation or treatment services pursuant to this article unless the sex offender evaluation or treatment services to be provided by such individual or entity conforms with the standards developed pursuant to Section 16-11.7-103(4) (b).”

(2) The board shall require any person who applies for placement on the list of persons who may provide sex offender treatment services pursuant to this article to submit a complete set of his or her fingerprints. The board shall forward any such fingerprints received pursuant to this subsection (2) to the Colorado Bureau of Investigation for use in conducting a state criminal history record check and for transmittal to the federal bureau of investigation for a national criminal history record check. The board shall use the information obtained from the state and national criminal history record check in determining whether to place the person on the approved provider list.
4. The Sex Offender Management Board will release information to all referring agencies regarding the status of my application, my placement on the Provider List, founded complaints, removal from the Provider List or denial of my application to the Provider List.
5. In the event a complaint is filed against me, the contents of my application will be reviewed by the Sex Offender Management Board in accordance with the Sex Offender Management Board Administrative Policies.
6. I have read the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* and/or the *Standards and Guidelines for the Evaluation, Assessment, Treatment, and Supervision of Juveniles Who Have Committed Sexual Offenses* in its entirety, and agree to carry out the *Standards* to the best of my ability related to the listing and level for which I am applying. I have answered all questions on this application honestly and the answers are complete to the best of my knowledge. I further understand that false statements or misstatements on this application are grounds for removal from the SOMB Provider Lists.
7. You **must** notify the SOMB, in writing, within two weeks, of any changes to your name, address, telephone number, program name, program materials, clinical supervisor (*submit a revised supervision agreement if your supervisor changes*) or if you have added an additional treatment location. This should be done as soon as possible to avoid administrative problems and ensure accurate placement on the approved provider list. If the staff of the SOMB cannot locate you or reach you, your name will be removed from the approved provider list.
8. You **must** provide the SOMB, in writing, within ten days, any changes to your professional status, such as grievances, license revocations, **criminal charges/arrest** or any other change in your professional standing. (Please reference administrative policies in SOMB standards).

Signature of Applicant: _____ Date: _____

Printed Name of Applicant: _____

How do I Complete the Fingerprint Card

Per Colorado Revised Statute 16-11.7-106 (2), applicants must submit one set of fingerprints for use by the Colorado Bureau of Investigation (CBI) and for transmittal to the Federal Bureau of Investigation (FBI). All new applicants are required to submit a fingerprint card unless you already have submitted a card to the Domestic Violence Management Board or to the Sex Offender Management Board.

Please carefully read the instructions below:

1. You **must use the fingerprint card that is enclosed** due to the specific coding on the card. Do not substitute it for a fingerprint card from your local law enforcement agency.
2. Take the enclosed card to your local law enforcement agency for fingerprinting. They will charge you a fee.
3. Pay close attention to the numbered description of each category that needs to be filled out on the fingerprint card. **Any inaccuracies will result in your card being returned to you.** This will delay the process and may result in additional fees.
4. Use **black ink only.**
5. All written information must be contained within each box. **Do not write on any blue lines.**
6. Do not highlight any information.
7. You must submit your completed fingerprint card (along with an enclosed **MONEY ORDER MADE OUT TO CBI FOR \$39.50**) to:

Sex Offender Management Board
Division of Criminal Justice
700 Kipling Street, Suite 3000
Denver, CO 80215

8. Insert information into boxes on fingerprint card according to the **sample** on the next page.

| | | | | | | | | |
|---|--|--|--|--|--|--------------|---|--|
| APPLICANT | | LEAVE BLANK | | TYPE OR PRINT ALL INFORMATION IN BLACK LAST NAME <u>NAM</u> FIRST NAME MIDDLE NAME (1) | | | FBI LEAVE BLANK | |
| SIGNATURE OF PERSON FINGERPRINTED (12) | | ALIASES <u>AKA</u> (2) | | ORI C0030085C ST DIV CRIM JUST DENVER, CO | | | DATE OF BIRTH <u>DOB</u> Month (10) Year | |
| RESIDENCE OF PERSON FINGERPRINTED (13) | | CITIZENSHIP <u>CTZ</u> (3) (3A) | | SEX <u>M</u> WGT. <u>150</u> EYES <u>BLU</u> HAIR <u>BRN</u> (4) (5) (6) (7) (8) (9) | | | PLACE OF BIRTH <u>POR</u> (11) | |
| DATE (14) SIGNATURE OF OFFICIAL TAKING FINGERPRINTS | | YOUR NO. <u>OCA</u> (20) | | LEAVE BLANK | | | | |
| EMPLOYER AND ADDRESS (15) | | FBI NO. <u>FBI</u> | | CLASS _____ | | | | |
| REASON FINGERPRINTED (16) | | ARMED FORCES NO. <u>MNU</u> | | REF. _____ | | | | |
| (16) | | SOCIAL SECURITY NO. <u>SSN</u> (17) | | MISCELLANEOUS NO. <u>MNU</u> (18) | | | | |
| (19) | | | | | | | | |
| 1. R. THUMB | | 2. R. INDEX | | 3. R. MIDDLE | | 4. R. RING | | |
| | | | | | | 5. R. LITTLE | | |

| | |
|--------------------|--|
| 1. Name | Type or print Last, First and Middle Name |
| 2. AKA | Maiden name, other married names or any other name used |
| 3. Citizenship | U.S. (if born in the U.S) or Alien registration number |
| 3A. AMOUNT | DO NOT FILL IN |
| 4. Sex Codes | M (Male) F (Female) |
| 5. Race Codes | W (White) B (Black) W (Hispanic) I (Indian) A (Asian –Oriental) |
| 6. Height | Feet and inches (for example 5’6” = 506; 6’ = 600) |
| 7. Weight | 090, 100, 250, etc. |
| 8. Eye Codes | BLK (Black), BLU (Blue), BRO (Brown), GRN (Green), GRY (Gray), HAZ (Hazel), XXX (Unknown) |
| 9. Hair Codes | BAL (Bald), BLK (Black), BRO (Brown), GRY (Gray), RED (Red/Auburn), WHI (White), XXX (Unknown) |
| 10. DOB | Date of Birth |
| 11. POB | Place of Birth |
| 12. Signature | Signature of person fingerprinted – Individual’s Signature |
| 13. Residence | Complete mailing address of person fingerprinted; includes city, state, & zip code |
| 14. Date | Date Printed; Signature of <u>Law Enforcement Official</u> taking fingerprints |
| 15. Employer | DO NOT FILL IN |
| 16. Reason Printed | DO NOT FILL IN |
| 17. SOC | Social Security Number |
| 18. Miscellaneous | DO NOT FILL IN |
| 19. Fingerprints | All Applicants prints should be taken by a law enforcement agency |
| 20. OCA | DO NOT FILL IN |
| 21. FBI | DO NOT FILL IN |