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
https://www.colorado.gov/dcj
Telephone: (303) 239-4526 or 4199 | Fax: (303).239.4491

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What Application Should I Be Using?

Application 1 – First Application for Associate Level

This application is used the first time an individual is applying to become an SOMB approved provider and will initiate the first year on the approved provider list. Application 1 is also used when a currently approved provider is applying to add an additional status to their listing (e.g. adding the DD/ID Specialty or Evaluator status).

Students: If you are a graduate student completing a practicum, internship or externship as a part of your degree requirements, and you have no intention of continuing to practice with adult sex offenders or juveniles who have committed a sexual offense, you DO NOT need to apply to the SOMB.

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 when an approved provider is applying to move from Associate Level to Full Operating Level status.

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

This application is used when a currently approved provider has completed Application 2 (and the accompanying 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 4.000 of the *Standards and Guidelines. They may be accessed via the following link: https://www.colorado.gov/pacific/dcj/somb-standards-bulletins*.

2. The Competency-Based Provider Approval Model Summary may be accessed via the following link: https://cdpsdocs.state.co.us/SOMB/APPLICATION/SOMBCompentencyAssessmentSummary.pdf.

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. Please note, applicants shall apply as individuals, not partnerships or programs.

Polygraph examiners should not submit this form.
Please see Polygraph Examiner applications via the following link:
https://www.colorado.gov/pacific/dcj/somb-provider-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 and Guidelines.* The applicant should first read and understand the *Standards and Guidelines* 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 the required attachments 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 application materials and current *Standards and Guidelines* are available at https://www.colorado.gov/dcj or by contacting (303) 239-4526.
- 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, 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 procedures.

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 note, your application is not considered complete until the fingerprint process is completed. Please see page nine (9) for further information.

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): ______________________________________

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Agency Telephone Number: ____

Business Email: ____

County of Primary Location: ____

Supervisor's Name: ____

Agency: ____

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

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Agency Telephone #: ____

Authorization for Release of Information

Adult and Juvenile Applicants

I, ______________________________, authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to be on the Sex Offender Management Board's Provider List as one or more of the following: **Associate Level Treatment Provider, Associate Level Evaluator, Full Operating Level Treatment Provider, Full Operating Level Evaluator, Developmental Disability Specialty.** I agree to give any further information that may be required in reference to my past record.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court association, or institutions having possession of any documents, records or other information pertaining to me, to furnish to the Sex Offender Management Board such information, including, but not limited to, documents and records, informal, pending or closed, or any other pertinent data and to permit the Sex Offender Management Board or any of its designated officers, committees, or staff to inspect and make copies of such documents, records and other information in connection with this application.

The foregoing authorization for release of information or records does not include consent for release of personal financial records, bank accounts, loans or other such personal information not related to my moral character, professional reputation, or fitness as a treatment provider and/or evaluator and/or polygraph examiner.

I hereby release, discharge and exonerate the Sex Offender Management Board, its agents and representatives, and any person furnishing such information from any and all liability of every nature and kind arising out of the furnishing of such information to other medical or professional societies or organizations, hospitals and hospital committees, and government agencies in the event that other such organizations and agencies present to the Sex Offender Management Board a release of authorization for release of information executed by me or a facsimile of such release or authority executed by me.

______________________________ ______________________________

Signature of Applicant **Clearly** Printed Applicant Name

____

Date

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.

- ☐ **Adult** Associate Level Treatment Provider
- ☐ **Juvenile** Associate Level Treatment Provider
- ☐ **Adult** Associate Level Evaluator
- ☐ **Juvenile** Associate Level Evaluator
- ☐ **Adult** Developmental/Intellectual Disability Specialty
- ☐ **Juvenile** Developmental/Intellectual Disability Specialty

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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 Section 4.000 of the SOMB *Standards and Guidelines*. 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 SOMB Competency-Based Provider Approval Model.

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

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Associate Level Contract

I am enclosing:

- Documentation/verification of my status with D.O.R.A. (i.e., copy of registration or licensure). Please review Section 4.100 of the SOMB *Standards and Guidelines*.
- Documentation/verification of my Academic Degree. (i.e., copy of degree or transcripts). Please review Section 4.100 of the SOMB *Standards and Guidelines*.
- Letter of reference.
- This signed application entitled **"Application 1 -First Application for Associate Level."**
- Competency rating from your SOMB approved clinical supervisor. You can find this form on the SOMB website via the following link: http://cdpsdocs.state.co.us/dvomb/SOMB/APP/Applications/TreatmentProviderCompentencyAssessment.pdf

Additionally:

- I have completed the fingerprint registration process. I am scheduled to provide my fingerprints on ___________________.

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
Print Applicant's Name

status, and that I am responsible for their clinical supervision. I am adhering to the SOMB Standards and Guidelines along with the Administrative Policies and have developed an individualized comprehensive supervision plan for ___________________ in accordance with the
Print Applicant's Name

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.

Applicant's Name (Please Print Clearly) ____

Applicant's signature: _________________________________**Date:** ___________________

Supervisor's Name (Please Print Clearly)____

Supervisor's signature: ________________________________**Date:** ___________________

The frequency of face-to-face supervision hours specific to sex offense specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

Will you be utilizing alternate forms of supervision, i.e., phone, video conferencing?

Yes No

If yes, please explain:

____

____

Statement of Understanding

Initial

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, including any revisions, and I understand 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.

Continues of next page

Statement of Understanding

8. I am in good standing as a mental health provider and adhering to all the requirements with the Department of Regulatory Agency. I **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 the Administrative Policies in the SOMB *Standards*).

Printed Name of Applicant:

Signature of Applicant: Date:

Printed Name of Clinical Supervisor: ____________________

Signature of Clinical Supervisor: ____________________ Date: __________

How to Submit Fingerprints

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). Fingerprints are submitted electronically. Additionally, all new applicants are required to submit fingerprints *unless you already have submitted a card to the Domestic Violence Management Board or to the Sex Offender Management Board.*

There are two approved vendors providing fingerprinting services on behalf of CBI and each vendor has multiple locations throughout Colorado. You must initiate the process through the vendor's website. When you register you will need the following information:

Colorado Fingerprinting
http://www.coloradofingerprinting.com

CBI Unique Code: 3906SOBI
Reason Fingerprinted: CONCJ3906

IdentoGo
https://www.identogo.com

Service Code: 25YH45
Reason Fingerprinted: CONCJ3906