

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

**Application 3  
Renewal of Current Listing**

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

**Associate and Full Operating Level Treatment  
Provider, Evaluator, and/or  
Clinical Supervisor**



**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**



**COLORADO**  
Department of Public Safety

# **What Application Should I Be Using?**

## **Application 1 – First Application for Associate Level**

Application 1 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 a current status for the next three (3) year renewal period.

## **Who Should Complete this Application?**

**This application should be completed by Associate/Full Operating Level Treatment Providers and/or Associate/Full Operating Level Evaluators as well as Clinical Supervisors who are RENEWING their listing with the SOMB in order to continue providing services to convicted adult sex offenders and/or adjudicated juveniles who have committed a sexual offense.**

If this is your **first** time applying as an Associate Level Treatment Provider or Evaluator, please complete Application 1. If this is your first time applying for a three year approval, please complete Application 2. Please note, applicants shall apply as individuals, not as 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 & Guidelines*. The applicant should first read and understand the *Standards and Guidelines* before completing this application.
- 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**.
8. **ALL** applicants **MUST** submit a money order or check for **\$125.00** made payable to **Colorado Department of Public Safety**. This is utilized to for the cost of your background check pursuant to C.R.S. and current Standards, which is required every three years. This fee is **NON-REFUNDABLE**.

**APPLICANT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **Provider #:** \_\_\_\_\_

(SOMB use only)

**For Continued Placement on the Sex Offender Management Board's Provider List as an Associate Level or Full Operating Level Treatment Provider and/or Evaluator.  
Adult and Juvenile Application**

Please check the categories for which you are applying

- ADULT ASSOCIATE LEVEL TREATMENT PROVIDER**  
\_\_\_\_\_DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY
- ADULT ASSOCIATE LEVEL EVALUATOR**  
\_\_\_\_\_DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY
- ADULT FULL-OPERATING LEVEL TREATMENT PROVIDER**  
\_\_\_\_\_DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY
- ADULT FULL-OPERATING LEVEL EVALUATOR**  
\_\_\_\_\_DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY
- JUVENILE ASSOCIATE LEVEL TREATMENT PROVIDER**  
\_\_\_\_\_DEVELOPMENTAL DISABILITIES/INTELLECTUAL DISABILITIES SPECIALTY
- JUVENILE ASSOCIATE LEVEL EVALUATOR**  
\_\_\_\_\_DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY
- JUVENILE FULL-OPERATING LEVEL TREATMENT PROVIDER**  
\_\_\_\_\_DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY
- JUVENILE FULL-OPERATING LEVEL EVALUATOR**  
\_\_\_\_\_DEVELOPMENTAL/INTELLECTUAL DISABILITIES SPECIALTY
- CLINICAL SUPERVISOR**

# Background and Identifying Information

## Adult and Juvenile Applicants

This information will be used by SOMB staff to conduct a criminal history check, a background investigation, and to document your qualifications.

Applicant Name: \_\_\_\_\_

Credentials (MA, LCSW, etc.): \_\_\_\_\_

Aliases: \_\_\_\_\_

Gender:  Male  Female Date of Birth: \_\_\_\_\_

Home Address: (Street, City, State and Zip Code): \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_

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.**

Employer Name: \_\_\_\_\_

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

\_\_\_\_\_

County of Primary Location: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

You may list up to five addresses and counties on the provider list. Please list the **full address**, the **County**, and **check Adult, Juvenile or Both**.

1. \_\_\_\_\_ County: \_\_\_\_\_

Adult Juvenile Both (Phone)

2. \_\_\_\_\_ County: \_\_\_\_\_

Adult Juvenile Both (Phone)

3. \_\_\_\_\_ County: \_\_\_\_\_

Adult Juvenile Both (Phone)

4. \_\_\_\_\_ County: \_\_\_\_\_

Adult Juvenile Both (Phone)

5. \_\_\_\_\_ County: \_\_\_\_\_

Adult Juvenile Both (Phone)

**Please list languages, other than English, which you speak fluently and in which you can demonstrate clinical proficiency (*this information will be published on the Provider List*):**

\_\_\_\_\_

# 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, Clinical Supervisor.** 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

## Recent Employment History (Attach Resume)

*Adult and Juvenile Applicants*

If your place(s) of employment and/or position has changed within the last three (3) years (i.e. since your last application) please provide that information below. A resume or curriculum vitae will also suffice if you wish to submit a copy. If nothing has changed please check the N/A box.

N/A

<i>Employer/Business Name:</i>	<i>Telephone:</i>	
<i>Street Address:</i>		
<i>City:</i>	<i>State:</i>	<i>Zip Code:</i>
<i>Position:</i>	<i>Dates of Employment:</i> <i>From</i> <i>To</i>	
<i>Unless you were self-employed, list supervisor name:</i>	<i>Telephone:</i>	
<i>If self-employed, provide the name of a professional reference to verify this employment:</i>	<i>Telephone:</i>	
<i>Summary of job duties:</i>		
<i>Reason for leaving:</i>		



# Background and Identifying Information Continued

- **Is your Colorado license to practice psychotherapy current?**

NO       YES

(\*A copy of your license must be attached to this application. (Sections 12-43-303, 12-43-403, 12-43-503, and 12-43-603, C.R.S.)

- **Have you received any form of professional discipline since the date of your last application?**

NO       YES

If yes, please explain and provide documentation of resolution regarding this matter.

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- **Have you been arrested, charged or convicted of any criminal offense since the date of your last application?**

NO       YES

If yes, please explain and provide documentation of resolution regarding this matter.

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- **Do you have any pending professional liability or malpractice actions, or final judgments or settlements involving your professional practice?**

NO       YES

If yes, please explain:

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# 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, 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 on next page*

# Statement of Understanding

Initial

8. I am in good standing as a mental health provider with the Department of Regulatory Agency. I **must** provide the SOMB, in writing, within ten days, any changes to my professional status, such as grievances, license revocations, criminal charges/arrest or any other changes to my professional standing. (Please reference the Administrative Policies in the SOMB Standards).

Printed Name of Applicant: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Clinical Supervisor (if applicable) \_\_\_\_\_

Signature of Clinical Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

# References

- The Sex Offender Management Board background investigator will contact a minimum of four of the six references as part of the background check.
- All references must be familiar with your sex offense specific work and at least two (2) of the references listed must be members of a Community Supervision Team (CST) and/or Multidisciplinary Team (MDT) in which you participate.
  - **DOC/DYS EMPLOYEES:** Since you may not be working with CST and/or MDT Teams you may provide names other professionals familiar with your sex offense specific work.
- If you are applying as an **Adult AND Juvenile Provider**, please provide references that can speak about your ability to work with **BOTH** populations.
- **If you are not providing direct clinical services**, please submit six references familiar with your work as it pertains to your work in the field of sex offender treatment and/or evaluation.

## PROFESSIONAL REFERENCES

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

**REQUIRED ADDITIONAL REFERENCES** - **Must** be familiar with your offense-specific work.

## **SUPERVISING OFFICER, PROBATION/PAROLE**

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

*Continues on next page*

**VICTIM ADVOCATE, VICTIM THERAPIST, VICTIM REPRESENTATIVE OR OTHER VICTIM PROFESSIONAL** - You must have a victim reference. If you don't, please contact the Adult Standards Coordinator or the Juvenile Standards Coordinator.

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

**POLYGRAPH EXAMINER, TREATMENT PROVIDER, EVALUATOR, OR OTHER** - Please indicate the individual's profession below.

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

# Specialized Training

*This form is required for all applicants.*

- Training attendance over the past **three (3)** years (**since your last reapplication**) will be considered. Please reference section 4.000 regarding specific training requirements.
- Specialized training is important to obtain since there is currently no graduate curriculum specialty area of sex offender treatment. Although you may have received excellent clinical supervision, you **may not** use clinical supervision as “training.”
- Generally the length of the workshop or training equals hours of training.
- You may count e-learning and CD/DVD trainings for **half (1/2) credit**. Actual courses or webinar trainings can count for full credit.
- If you were the trainer, you may count the training you conducted as long as it does not exceed more than half of your total hours.
- Only 25% of the total required training hours can be comprised of in-house training within your agency/program.
- Please note the SOMB Standards requires that every three (3) years the provider shall complete forty (40) hours of training, which includes the SOMB Introductory training to the Standards or the SOMB Standards Booster training. Please review Section 4.000 for specific training requirements.
- You may count committee participation at 1 hour per meeting with a maximum of 6 hours which can be applied to the required number of training hours.
- **The SOMB staff may request copies of training certificates at any time and may conduct standard compliance reviews.**

**BY SIGNING THIS FORM YOU ARE ATTESTING TO THE FACT THAT YOU HAVE ATTENDED THE TRAINING REQUIRED ACCORDING TO THE COMPETENCY-BASED PROVIDER APPROVAL MODEL RESPECTIVE TO YOUR SPECIFIC LISTING STATUS.**

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Clinical Supervisor

\_\_\_\_\_  
Signature of Clinical Supervisor

\_\_\_\_\_  
Date

# Professional Supervision Agreement For Associate Level Treatment Providers and/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 SOMB 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 information changes, including a change with supervision, 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:**

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

# Qualifications of Treatment Providers and/or Evaluators

## *Adult and Juvenile Applicants*

### **Required Attachments**

- Associate Level providers:
  - An updated competency rating from your clinical supervisor for the past three years. Competency Assessments may be downloaded via the following link: <https://www.colorado.gov/pacific/dcj/somb-provider-applications>.
  - A narrative as to how you are staying active in the field (which may include training, research you have read or participated in, and further information regarding current treatment, consultation or supervision practices you have engaged in during this renewal cycle).
  - Evidence of registration as a Registered Psychotherapist OR evidence of Licensure.
  - Copy of your current Driver's License.
  - \$125.00 check or money order made out to Colorado Department of Public Safety.
  
- Full-Operating Level provider or SOMB Clinical Supervisor:
  - A narrative as to how you are staying active in the field (which may include training, research you have read or participated in, and further information regarding current treatment, consultation or supervision practices you have engaged in this during this renewal cycle).
  - Evidence of registration as a Registered Psychotherapist OR evidence of Licensure.
  - Copy of your current Driver's License.
  - \$125.00 check or money order made out to Colorado Department of Public Safety.



# Request for Waiver of Qualifications of Treatment Providers and/or Evaluators

## Adult and Juvenile Applicants

I \_\_\_\_\_, am requesting a waiver of certain criteria for the Qualifications of  
Print Applicant's Name  
Treatment Providers and/or Evaluators. I understand that due to my lack of being able to provide all required documentation or information required by the SOMB Standards, there may be certain conditions I must agree to in order to obtain approval of the requested listing.

Please indicate which requirement you wish to have waived below and provide an explanation as to why you have not been able to meet this requirement.

- Professional Reference
  - o Type: \_\_\_\_\_

Please explain:

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- Training Requirements
  - o Introduction or Booster

If yes, please explain:

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- o Hours Requirement:
  - Amount Completed: \_\_\_\_\_

If yes, please explain:

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Other: \_\_\_\_\_

Please explain:

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