APPLICANT NAME:

DATE:

APPLICATION FOR DV CLINICAL SUPERVISOR LEVEL PLACEMENT ON THE APPROVED PROVIDER LIST

COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD

COLORADO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF CRIMINAL JUSTICE

700 Kipling Street, Suite 1000
Denver, CO 80215
Tel: (303) 239-4528 or 1-800-201-1325 (in Colorado only)
Fax: (303) 239-4223
http://dcj.dvomb.state.co.us

January 2017

Required Documentation Checklist

Reference the Standards, Section 9.03

PLEASE NOTE: There is no fee if you are a DVOMB Approved Provider Listed at the Full Operating Level and wish to obtain your DV Clinical Supervisor Level.

In addition to all Full Operating Level requirements, the following is a list of all documentation required for DV Clinical Supervisor Approval:

1. **____Submit a copy of your professional mental health license from the Colorado Department of Regulatory Agencies (DORA). Certifications such as CAC I, II or III do not meet this requirement.**

2. **____49 hours of training specific to substance abuse and addiction**, *Section 9.03 I, (B)*
   a. CAC II, CAC III or LAC will fulfill this requirement. Please send a copy of your CAC certificate or LAC License *OR*
   b. Submit copies of training certificates.

3. **____21 hours of training in clinical supervision**, *Section 9.03 I, (C)*
   a. CAC III or LAC will fulfill this requirement. Please send a copy of your CAC Certificate or LAC License *OR*
   b. Submit copies of training certificates.

4. **____75 additional hours of face-to-face client contact hours working with domestic violence offenders with a minimum of one (1) year of DV treatment provision at the Full Operating Level,** *Section 9.03, I (D)*
   Note: These hours are in addition to the required hours for Full Operating Level Approval.

   a. Provide a letter from a Full Operating Level Provider documenting 75 face-to-face client contact hours.

5. **____100 hours of providing general clinical supervision during the past five years**, *Section 9.03, I (E)*
   a. Provide a letter from a Full Operating Level Provider or a DV Clinical Supervisor documenting the 100 hours of providing general clinical supervision *OR*
   b. Provide a letter from a DV Clinical Supervisor documenting your intent to obtain ongoing consultation regarding supervision until your 100 hours are obtained.

6. **____Submit two formal written evaluations, two treatment plans and two treatment contracts** as prescribed in Standards, Sections 4.00 and 5.00. (See page 6 of this application)

7. **____Complete and submit pages 1-10. Please submit all materials on SINGLE-SIDED COPIES.**

Identifying Information

Date: ______________________________

Applicant Name: ____

Credentials (LCSW, LAC, etc.): ____

Maiden Name/other names used: ____

Cell phone number (if possible): ____

E-mail is the most cost-effective and efficient way to communicate with you. Please provide your email address below.

____

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

******Requested information below is public record. For safety reasons, do not use home information******

Please list for #1 AGENCY (below) your **PRIMARY** office where you wish correspondence to be mailed to you:

#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.

- -

#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 #
_____

- Do you have a current Colorado license to practice psychotherapy?
  ☐ **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.)

- Is there any pending professional discipline or 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 the resolution.

_____

_____

- Are there any pending arrests, charges or convictions or 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 the court's disposition.

Statement of Compliance for Clinical Supervisors

Reference the Standards, Section 9.03 (G) (H)

I have read and understand the *Standards for Treatment with Court Ordered Domestic Violence Offenders* in their entirety and agree to provide supervision in accordance with *the Standards*.

I confirm that I have read and understand the DVOMB Application Policies pertaining to the responsibilities of DV Clinical Supervisors. (Reference Standards 9.0, including 9.04, Entry Level Application, Full Operating Level Application and Provisional Application packets.)

I further agree to inform the Board in writing of all applicants/providers that I currently supervise. I will also advise the Board of any additions or deletions of applicants/providers from my supervision.

_____

Applicant/Provider Name (type or print legibly)

_____

Signature of Applicant/Provider (Date)

Domestic Violence Offender Evaluations

Reference the Standards, 4.00

Providers have an ethical responsibility to conduct evaluation procedures in a manner that ensures the integrity of testing data, the humane and ethical treatment of the offender, and in compliance with mental health statutes. Providers should use testing instruments in accordance with their qualifications and experience. I understand that training and education are required for the administration, scoring and interpreting of assessment instruments. I verify that I have the credentials and training required by the publisher for those instruments I have checked "Yes" below. For those I have checked "No," I verify I have a qualified supervisor or referral source to address the areas, if indicated.

- Adhering to the established ethical standards, practices and guidelines of your profession, are you qualified in the following areas?

☐ **NO**	☐ **YES**	ASI (Addiction Severity Index)
☐ **NO**	☐ **YES**	SASSI (Substance Abuse Subtle Screening Inventory)
☐ **NO**	☐ **YES**	ASUS-R (Adult Substance Use Survey – Revised)
☐ **NO**	☐ **YES**	DVRNA (Domestic Violence Risk & Needs Assessment)
☐ **NO**	☐ **YES**	SARA (Spousal Assault Risk Assessment)
☐ **NO**	☐ **YES**	MCMI II or III (Millon Clinical Multiaxial Inventory)
☐ **NO**	☐ **YES**	MMPI – 2 (Minnesota Multiphasic Personality Inventory)
☐ **NO**	☐ **YES**	DVI - Domestic Violence Inventory
☐ **NO**	☐ **YES**	DVRAG - Domestic Violence Risk Appraisal Guide
☐ **NO**	☐ **YES**	MMSE (Mini Mental Status Exam)
☐ **NO**	☐ **YES**	STAXI – State-Trait Anger Expression Inventory
☐ **NO**	☐ **YES**	other _____
☐ **NO**	☐ **YES**	other _____
☐ **NO**	☐ **YES**	other _____

If you have checked "no" to any item above, please describe how you would assess an offender in this area if needed.

_____

_____

1. Please submit one **Offender Evaluation (Standards section 4.0**), corresponding **Individualized Treatment Plan (Standards section 5.0)** and **Offender Contract (Standards section 5.0)** that you have co-designed for each population you are seeking approval for (i.e. male, female*, same sex*). If you are applying to work strictly with male offenders, you must submit 2 evaluations, treatment plans and contracts that you have co-designed on male offenders. *If you are seeking approval for Female and/or Same Sex, you must submit application for specific offender populations.
2. Offender Evaluations, Individualized Treatment Plans and Offender Contracts must be formal written documents containing all required components of Standards 4.0 and 5.0. Copies must be of actual offender evaluations, treatment plans and offender contracts (with client identifying information omitted).
3. The evaluations must be signed by your DV Clinical Supervisor to indicate that he or she has reviewed and approved it. They must be accompanied by a signed and completed Assessment of Applicant's Evaluations by DV Clinical Supervisor form for each evaluation (SEE PAGES 7-9).

Assessment of Applicant's Evaluations by DV Clinical Supervisor

This form must be completed by your DV Clinical Supervisor and submitted with your evaluation and treatment plan. DV Clinical Supervisors are also encouraged to make copies of this form to use as a training tool with supervisees.

Applicant/Supervisee Name:_____

DV Clinical Supervisor Name:_____

Today's Date:_____

ALL ELEMENTS BELOW ARE REQUIRED

STANDARD

4.06 Identify Referral Source? _____ _____

Identify when evaluation was completed? (e.g. post plea, pre-sentence, post sentence)

_____ _____

4.08 Identify minimum mandatory source of information?

External sources of information:

Criminal Hx/other CJ info _____ _____

Police report _____ _____

Victim Impact Statement or victim input (if avail)_____ _____

Previous evaluations_____ _____

Available collaterals_____ _____

PSI if available _____ _____

Internal sources of information:

Clinical interview_____ _____

Risk assessments_____ _____

Required Assessment Instruments (used and scored correctly?):

2nd risk assessment_____ _____

Substance Abuse Screening Instruments_____ _____

DVRNA_____ _____

Required in Clinical Interview:

Psychosocial History_____ _____

Mental health history_____ _____

Cognitive screen_____ _____

Substance use history_____ _____

Relationship history (DV dynamics)_____ _____

4.07 The evaluation shall not make a determination of guilt or innocence.

_____ _____

Did the evaluation identify the following?

Specific victim safety issues_____ _____

Risk of re-offense or abuse_____ _____

Criminogenic factors & needs_____ _____

Potential destabilizing factors_____ _____

Motivation/responsivity/amenability to tx_____ _____

Offender accountability_____ _____

Strengths & Weaknesses_____ _____
Initial level of placement in treatment (based on DVRNA)
_____ _____
Initial tx recommendations_____ _____
Was the evaluation co-signed by an approved DVOMB Provider?_____ _____

4.09 If offender was found to be *inappropriate* for DV tx, was criteria in 4.09 addressed? _____

10.01 For female or same sex specific, were tx recommendations compliant with 10.06, 10.07 and 10.08?_____ _____

REQUIRED EVALUATIONS COMPETENCIES

Applicant demonstrates the following:

1. Knowledge of, use of and accurate reporting of findings from DVRNA. (Additionally consider the following: *Was there not enough information to determine if the following items should have been scored, although there was indication that it should be explored further*? *Were any of the instruments scored incorrectly based on the information provided in the evaluation report*?)

_____

_____

_____

2. Case Conceptualization- (*All information has been utilized to identify conclusions and treatment needs. Data is synthesized and findings are clearly explained*) _____

_____

_____

3. All required components of 4.0_____

_____

4. Understanding of DV dynamics, contributing factors and relevant treatment recommendations_

_____

_____

5. Tx goals reflective of offender dynamics and needed behavioral changes_____

_____

_____

6. An identification & subsequent explanation of information that is missing _____

_____

_____

TREATMENT PLANS
Standard, 5.05
Does the plan promote victim safety?_____

_____

Does the plan identify containment goals?_____

_____

Does the plan promote risk reductions?_____

_____

OFFENDER CONTRACTS
Standard, 5.05 (II)
Does the Offender Contract meet 5.05 (II) A-D? _____

_____

DV CLINICAL SUPERVISOR'S NOTES:

Evaluations accepted.

Treatment Plans accepted.

Treatment Contract accepted.

Accepted with comments: please attach any additional comments.

I attest that I have reviewed this evaluation and treatment plan for compliance with the *Standards for Treatment with Court Ordered Domestic Violence Offenders*, sections 4.0 and 5.0. I approve of its submission to the DVOMB.

_____

DV Clinical Supervisor Signature Date

Verification of Ongoing Peer Consultation

Reference the Standards, 9.02, V. (A) (B)

I, _____ do hereby verify that I have been
(Full Operating Level Provider or DV Clinical Supervisor Peer Consultant)

participating in peer consultation for a minimum of two hours per month as per the Standards,

Section 9.02, V. (A) (B) with _____.
(DV Clinical Supervisor Applicant)

_____
(Signature of Full Operating Level Provider DV Clinical Supervisor Peer Consultant) Date

Verification of Proposed Peer Consultant

Reference the Standards, 9.03, II (A)

I, _____ do hereby verify that I will
(Licensed Full Operating Level Provider or DV Clinical Supervisor)

participate in peer consultation for a minimum of two hours per month per the Standards, Section 9.03,

II (A) with _____.
(DV Clinical Supervisor Applicant)

Peer consultation may include electronic modes of consultation (such as telephone, audio/videotape, teleconferencing, and Internet). If electronic modes of consultation are utilized, face-to-face consultation shall occur on no less than a quarterly basis. Standards, 9.03, Section II, (B)

_____
(Signature of Licensed Full Operating Level Provider or DV Clinical Supervisor Peer Consultant) Date