COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD (DVOMB)
&
COLORADO SEX OFFENDER MANAGEMENT BOARD (SOMB)

APPLICATION FOR ADULT FULL OPERATING LEVEL SOMB APPROVED PROVIDER TO BE APPROVED AS A FULL OPERATING LEVEL DVOMB APPROVED PROVIDER

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) 239-4491
http://dcj.dvomb.state.co.us

Who should complete this application?

Adult Full Operating Level Sex Offender Management Board (SOMB) Approved Treatment Providers and/or Evaluators who are applying to become Full Operating Level Domestic Violence Offender Management Board (DVOMB) Approved Providers in order to provide services to convicted domestic violence offenders as per Section 9.0 in the *Standards for Treatment with Court Ordered Domestic Violence Offenders* (hereafter referred to as the Standards).

It is the opinion of the SOMB and the DVOMB that a Full Operating Level SOMB Treatment Provider and/or Evaluator, due to the education, training and experience required for SOMB approval, has substantially met many of the requirements for a DVOMB Full Operating Level Provider. In acknowledgment, this application was developed to offer a more streamlined process for the SOMB provider to apply to the DVOMB Approved Provider List.

It is the applicant's responsibility to ensure he/she obtains the most current version of the Standards. Applicants apply as individuals, not partnerships or programs. Applicants must demonstrate that they meet the qualifications of, and will comply with, standards of practice contained in the Standards.

This application is for applicants applying to work with male domestic violence offenders. If an applicant is seeking to also work with female or same-sex domestic violence offenders, please refer to Standard 10.0, complete the Special Offender Population application and submit it with this application.

INSTRUCTIONS

1. Use ONLY the forms provided.
2. Submit ONLY the information requested.
3. Submit the required information in the order requested.
4. Follow all instructions carefully – incomplete or incorrect applications may be returned.
5. A money order for **$200.00** made payable to **Colorado Department of Public Safety** must be included for processing
5. The Application Review Committee (Committee) meets monthly. New applications are normally reviewed within one to two months of receipt. The Committee will then notify the applicant of any missing documentation. Applications must be completed within eight months from date of submission. (Please refer to administrative policy on time limits in Appendix D of the *Standards*.)
6. PLEASE DO NOT use staples, paper clips, binders, sheet protectors, or other materials. Please submit all materials on SINGLE-SIDED COPIES.

THE STANDARDS WILL SUPERCEDE IN THE EVENT OF ANY ERRORS IN THIS APPLICATION.

Frequently Asked Questions
FAQ's

How can the applicant prepare for completing this application?

- **The applicant should first read and understand the *Standards* before completing this packet.** Applicant may follow along using the *Standards* to clarify application requirements. Applicants will also need to meet with their DV Clinical Supervisor in completing the application.

What should the applicant do upon completion of this application?

- When completed, send application in hard copy to: Domestic Violence Offender Management Board/Division of Criminal Justice, 700 Kipling Street, Suite 1000, Denver, CO 80215.
(Please keep a copy of your completed application for your records.)

How long will the entire application review process take?

- The Committee will usually review your application within one to two months of receipt. You can expedite the process by submitting all of your application materials at one time and in the required order. If your packet is incorrect or incomplete, this slows down the approval process.

Where can I find additional copies of the Standards and application forms?

- Additional copies of the *Standards* and application materials may be obtained by calling (303) 239-4528. They are also available at: http://dcj.state.co.us.

What if an applicant has questions or needs more information?

- For questions, contact Sharon Behl, Standards Coordinator at (303) 239-4536 or Sharon.Behl@state.co.us.

How will compliance with the Standards be assured?

- Compliance with the *Standards* will be assessed through reapplication and possible audits. Mechanisms are in place to receive and investigate complaints through the Department of Regulatory Agencies.

APPLICATION FOR
ADULT FULL OPERATING LEVEL
SOMB APPROVED PROVIDER
TO BE APPROVED AS A
FULL OPERATING LEVEL
DVOMB APPROVED PROVIDER

Section 1. Background and Identifying Information

Applicant Name: _____
(You must apply as an individual, not as a program or partnership.)

Maiden Name/other names used:_____

Salutation (Mr., Ms., etc.): _____Date of Birth: _____

Cell phone number: _____

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 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 #
____

Section 2. Certification and Licensure

- 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.)

  If you are not licensed:

  Is your Registered Psychotherapist status current with DORA? (A copy of your registration must be attached to this application 12-43-702.5, C.R.S.) This requirement applies to ALL applicants, including DOC employees.

  ☐ **NO** ☐ **YES** If no, please explain: _____

- Are there currently any pending complaints against your license, certification or registration through any licensing or certifying body or professional organization?

  ☐ **NO** ☐ **YES** If yes, please explain:

  _____

  _____

- Have you received any form of professional discipline since the date of your application to the Sex Offender Management Board?

  ☐ **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 application to the Sex Offender Management Board?

  ☐ **NO** ☐ **YES** If yes, please explain and provide documentation of the court's disposition.

  _____

  _____

Section 3. DORA Verification

DEPARTMENT OF REGULATORY AGENCIES (DORA)
VERIFICATION FORM

****

_____

PRINT NAME Last First Middle (Maiden Name)

_____

ADDRESS Street City State Zip

****

I hereby authorize the Department of Regulatory Agencies to release information regarding the status of my license, registration and/or certification, complaints, and any disciplinary actions.

_____

Applicant Signature Date

Section 4. Statement of Understanding

I understand that the information I have submitted for this application to the Domestic Violence Offender Management Board (hereafter Board) for placement on the Approved Provider List will be used for the following purposes:

1. To create and disseminate a list of Approved Treatment Providers.
2. To create a database of information on the availability of domestic violence offender treatment services in Colorado.
3. My application materials will become public record of the Division of Criminal Justice and may be subject to the open record act requests pursuant to §24-72-304 C.R.S.
4. The Board will release information regarding the status of my application, my placement on the Approved Provider List and any information regarding any Board decision to remove me from the Approved Provider List or denial of my application for placement on the Approved Provider List to all referring agencies.
5. If any complaints are filed against me, or my services, this application may be re-reviewed.
6. I understand that by applying for approval, I agree to be audited for compliance with the *Standards* when necessary.
7. I understand that any applicant who is denied placement on the Provider List may appeal the decision. Reference: *Standards*, Appendix D-9 Appeals Process
8. I understand that if my name is included erroneously on the Approved Provider List, the Board may remove it without due process.

Inclusion on the Approved 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 Approved Provider List, it means that I am eligible to be considered for referral as a provider of treatment services for court ordered domestic violence offenders, pursuant to §16-11.8-104, C.R.S. which states:

On or after January 1, 2001, the Department of Corrections, the Judicial Department, the Division of Criminal Justice within the Department of Public Safety or the Department of Human Services shall not employ or contract with and shall not allow a domestic violence offender to employ or contract with any individual or entity to provide domestic violence offender treatment evaluation or treatment services pursuant to this article unless the individual or entity appears on the approved list developed pursuant to§16-11.8-103(4), C.R.S

Signature of Applicant: _____ Date _____

Name of Applicant (type or print legibly):_____

Section 5. Statements of Compliance

I have read and understood the *Standards for Treatment with Court Ordered Domestic Violence Offenders* in their entirety and agree to comply with the *Standards*. I have answered all questions on this application fully and my answers are complete and true to the best of my knowledge. I further understand that false statements or material misstatements in this application are cause for non-approval or for removal from the Approved Provider List.

If approved, I agree to treat the domestic violence offender population and the sex offender population separately according to the *Standards for Treatment with Court Ordered Domestic Violence Offenders* and the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders*.

Signature of Applicant: _____

Date _____

Applicant Name (type or print legibly): _____

Research Statement of Compliance

I agree to provide data and documentation as requested by the Domestic Violence Offender Management Board for the purposes of research or evaluation as required by §16-11.8-103 C.R.S. Reference: *Standards*, Section 11.12.

(Please initial) _____

Section 6. Verifications

A. Verification of Trainings

Reference the Standards Section 9.01 (J)

Directions for Applicant

20 hours of documented training specifically related to domestic violence evaluation and treatment methods are required. **11** of the **20** hours must be the specific trainings listed below. The remaining 9 hours must be in any of the **DV specific** training areas listed in Standards, Section 9.02 III.

.

Please list the trainings you attended using the title printed on the certificate and indicate the date and the number of hours. You must complete the required trainings listed below. *You must submit a **copy** of your certificate of attendance for each training you attend.*

20 Hours of Required Training	**Date**	**Hours**
· 7 Hour DVOMB Current Standards Training	_____	**7**
· DVRNA Training (from DVOMB only)	_____	**4**
· TITLE:_____	_____	_____
· TITLE:_____	_____	_____
	TOTAL:	_____

REQUIRED TRAININGS MINIMUM TOTAL: 20

_____

(Applicant Signature) (Date)

B. Verification of Experiential Hours

Clinical Substance Abuse Treatment Hours

Reference the Standards Section 9.02 I.(A) and II.(C)

Directions for Applicant:

Please have your domestic violence clinical supervisor verify these hours and complete this form. Supervisors may require applicant to provide verification and/or obtain additional supervisors' signatures.

I, _____ do hereby verify that I have reviewed
(DV Clinical Supervisor)

documentation and that _____:
(Applicant)

- ❑ Completed 50 face-to-face client contact providing clinical substance abuse treatment at

_____
(Name of agency where experience was gained)

OR

- ❑ Applicant possesses a CAC I, II or III or LAC. Enter CAC or LAC number. _____

_____
(DV Clinical Supervisor signature)

C. Ongoing Co-facilitation

Reference the Standards, Section 9.00

Directions for Applicant:
Please complete either the top half **or** the bottom half of this page.

Court ordered domestic violence offender treatment shall only be provided by an Approved Provider. Therefore, while an applicant is in training and/or application process, all face-to-face sessions with clients must be co-facilitated with a Full Operating Level DVOMB Approved Provider or a DV Clinical Supervisor. This includes individual sessions, group sessions and evaluations pursuant to §16-11.8-104, C.R.S.

I, _____, do hereby verify that I am co-facilitating
(Approved Domestic Violence Treatment Provider)

all domestic violence offender treatment, as described above and required by *Standards,* Section 9.01

(G), with the following applicant: _____.
(Applicant)

I further verify that I will continue to provide co-facilitation for this applicant during their entire application process, which I understand may continue for several months or longer. If I need to discontinue my co-facilitation, I will notify the DVOMB office at 700 Kipling Street, Suite 1000, Denver, CO 80215.

_____
(Approved Domestic Violence Treatment Provider's Signature) (Date)

IF YOU ARE NOT CURRENTLY WORKING IN DOMESTIC VIOLENCE OFFENDER TREATMENT, COMPLETE THIS PORTION OF THE FORM BELOW:

I, _____ do hereby verify that I am **not** currently
(Applicant)
working in the domestic violence offender treatment field. If I wish to provide any services for court ordered domestic violence offenders, I will notify the DVOMB immediately and have my co-facilitator complete the top portion of this form.

_____
(Applicant) (Date)

D. Applicant Competencies

Please complete the following section with your DV Clinical Supervisor.

DV CLINICAL SUPERVISOR CONTACT INFORMATION

Name of DV Clinical Supervisor

Agency Name (if applicable)

Street Address

City **State** **Zip**

Telephone: **Fax:**

E-mail:

I, _____ hereby verify
(DV Clinical Supervisor)

that _____
(Applicant)

and I have addressed the applicant's needs for competency in the field of domestic violence offender management including, but not limited to, provision of treatment, evaluation and offense specific case management by using the Multi-disciplinary Treatment Team.

We have completed the Applicant Competencies (please attach) and are in agreement that the applicant meets the requirements for application to the DVOMB Approved Provider List at the Full Operating Level.

_____
(Applicant signature) (Date)

_____
(DV Clinical Supervisor signature) (Date)

PLEASE ATTACH THE COMPLETED APPLICANT COMPETENCIES

E. DV Offender Treatment Philosophy Statement

Standards, Section 9.07 (a)

Submit your philosophy regarding domestic violence offender treatment. In a one-page statement, please include your viewpoints regarding causal factors of domestic violence, key treatment issues for offenders and victim safety issues. Also include your plan on how you will be maintaining cooperative working relationships within your community in the following areas: domestic violence victim services, other treatment providers, criminal justice programs, alcohol/drug abuse programs and social services. Please keep in mind it is recommended that providers attend community-based task force meetings that may address all the above listed areas.

F. Offender Evaluations, Treatment Plans, Contracts & *Assessment of Applicant's Evaluations by DV Clinical Supervisor*

Standard,s 4.00 and 5.00.

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 15-17)

Please submit all materials to:

Carolina Thomasson
Standards Coordinator
DVOMB
700 Kipling Street, Suite 1000
Denver, Colorado 80215
303-239-4536
Carolina.thomasson@state.co.us

G. Letter from DV Victim Advocate
(a). Probation Officer Reference Letter

Please have a Probation Officer (or Probation Officer Supervisor) whom you work with on a Multi-disciplinary Treatment Team (MTT) fill out the following form completely and accurately. This individual may be contacted by DVOMB for more information. This form is a required component of your application. You may submit this form with your application, or your reference may submit it separately at the time you are seeking approval with the DVOMB.

Applicant Name: _____
Probation Officer Name: _____
Judicial District: _____
Address: _____
Office phone: _____Cell Phone: _____
E-Mail Address: _____
Please answer the following questions regarding this applicant and his/her work with the domestic violence offender population:

1. How long have your worked with this applicant, and in what capacity?

_____
_____
_____
_____

2. How well does this applicant know and follow the DVOMB Standards when working with domestic violence offenders?

_____
_____
_____
_____

3. What are strengths you see in this applicant?

_____
_____
_____
_____

4. What areas of improvement do you believe this applicant should focus on?

_____
_____
_____
_____

Please provide any additional comments which you believe may be useful to the Application Review Committee regarding this applicant:

_____
_____
_____
_____

G (b). DV Clinical Supervisor Reference Letter

Please have your Domestic Violence Clinical Supervisor fill out the following form. This individual may be contacted by DVOMB for more information. This form is a required component of your application. You may submit this form with your application, or your reference may submit it separately at the time you are seeking approval with the DVOMB.

Applicant name: _____
DV Clinical Supervisor Name: _____
Agency: _____
Address: _____
Office phone: _____Cell Phone: _____
E-Mail Address: _____

Please answer the following questions regarding this applicant and his/her work with the domestic violence offender population:

1. How long have your worked with this applicant, and in what capacity?

_____
_____
_____
_____

2. How well does this applicant know and follow the DVOMB Standards when working with domestic violence offenders?

_____
_____
_____
_____

3. What are strengths you see in this applicant?

_____
_____
_____
_____

4. What areas of improvement do you believe this applicant should focus on?

_____
_____
_____
_____

Please provide any additional comments which you believe may be useful to the Application Review Committee regarding this applicant:

_____
_____
_____
_____

E(c). Treatment Victim Advocate Reference Letter

Please have your Treatment Victim Advocate fill out the following form. This individual may be contacted by DVOMB for more information. This form is a required component of your application. You may submit this form with your application, or your reference may submit it separately at the time you are seeking approval with the DVOMB.

Applicant name: _____
Treatment Victim Advocate Name: _____
Agency: _____
Address: _____
Office phone: _____Cell Phone: _____
E-Mail Address: _____

Please answer the following questions regarding this applicant and his/her work with the domestic violence offender population:

1. How long have your worked with this applicant, and in what capacity?

_____
_____
_____
_____

2. How well does this applicant know and follow the DVOMB Standards when working with domestic violence offenders?

_____
_____
_____
_____

3. What are strengths you see in this applicant?

_____
_____
_____
_____

4. What areas of improvement do you believe this applicant should focus on?

_____
_____
_____
_____

Please provide any additional comments which you believe may be useful to the Application Review Committee regarding this applicant:

_____
_____
_____
_____

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?):

SARA _____ _____

Substance Abuse Screening Instruments_____ _____

DVRNA_____ _____

Required in Clinical Interview:

Psychosocial History_____ _____

Mental health history_____ _____

Mini Mental Status Exam *or*

Colorado Criminal Justice Mental health 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 and SARA. (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