APPLICANT NAME:

DATE:

MOVE-UP APPLICATION FROM ENTRY LEVEL TO FULL OPERATING 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

June 2017

TABLE OF CONTENTS

Information for Moving Up from Entry Level to Full Operating Level Placement on the DVOMB Approved Provider List

Who should fill out this application?

This application is for DVOMB Approved Entry Level Providers wishing to be placed at the **Full Operating Level** on the Approved Provider List of Domestic Violence Offender Treatment Providers (hereafter called the Approved Provider List). Applicants must prove that they meet the qualifications and comply with standards of practice contained in the *Standards for Treatment with Court Ordered Domestic Violence Offenders* published by the Domestic Violence Offender Management Board (hereafter referred to as the *Standards*). **It is the applicant's responsibility to ensure they obtain the most current version of the *Standards***. Applicants should apply as individuals, not partnerships or programs.

This application is for applicants applying to work with male domestic violence offenders.

If an applicant is seeking to work with female or same-sex partner domestic violence offenders, please refer to *Standard 10.0* and 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. The Application Review Committee (Committee) meets monthly. New applications are normally reviewed by the Committee within one to two months of receipt. Applicants will be contacted following the Committee's review. Applications must be completed within eight months from date of submission. (Please refer to Standards, Appendix D.)
6. PLEASE DO NOT use staples, paper clips, binders, sheet protectors or other materials. Please submit all materials on SINGLE-SIDED COPIES.
7. A money order for $100.00 made payable to Colorado Department of Public Safety must be included for processing.
9. If you are currently a PROVISIONAL PROVIDER, please stop here and contact Carolina Thomasson, Standards Coordinator, for further instructions at either 303-239-4526 or Carolina.thomasson @state.co.us.

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

Frequently Asked Questions (FAQ)

How can an applicant prepare for completing this application?

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

What should an 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. (Note: if your packet is incorrect or incomplete, this slows down the approval process).

Where can additional copies of the Standards and application forms be found?

- 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/odvsom

What if an applicant has questions or needs more information?

- For questions, contact the Domestic Violence Offender Management staff at (303)-239-4528.

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.

PLEASE REMOVE PAGES 2-5 BEFORE RETURNING THE APPLICATION.

GENERAL REQUIRED FORMS

Directions for Applicant:

The following is a list of all documentation required for Section II. You must use the forms provided. You may use this page for reference and as your checklist to ensure that you are including all of your required documentation.

Section I General Required Forms:

A. Applicant Contact Information

B. References

C. Certification and Licensure

D. Criminal Background Information

E. Statement of Understanding

F. Statements of Compliance

SECTION I

A. Applicant Contact Information

Applicant Name: ____

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.

____

□ DO NOT PUBLISH my email on the Approved Provider List.

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.

- -

Please list up to three ***other*** offices where you provide DV treatment:

#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 # ____

B. **(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:

_____
_____
_____
_____

Probation Officer Signature: _____

E (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:

_____
_____
_____
_____

Domestic Violence Clinical Supervisor Signature: _____

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:

_____
_____
_____

Treatment Victim Advocate Signature: _____

SECTION I

C. Certification and Licensure

- Do you have a current Colorado license, certification or registration from the Department of Regulatory Agencies to practice psychotherapy? ☐ YES ☐ NO

If yes, please indicate type:

☐ Physician
☐ Social Worker Level _____ (Please specify)
☐ Alcohol & Drug Abuse Counselor, Level ____ (Please specify)
☐ Licensed Addiction Counselor
☐ Registered Psychotherapist
☐ Psychiatric Clinical Nurse Specialist
☐ Licensed Marriage and Family Therapist
☐ Licensed Professional Counselor
☐ Psychologist
☐ Other (Please specify) _____

- Are there currently any pending complaints against your license, certification or registration through any licensing or certifying body or professional organization? ☐ YES ☐ NO

  If yes, please explain: _____

- Since submitting your application for Entry Level Treatment Provider, have you been disciplined and/or found to engage in unethical behavior by any licensing or certifying body or professional organization? ☐ YES ☐ NO

  If yes, please explain: _____

- Since submitting your application for Entry Level Treatment Provider have you had a license or certification revoked, suspended, renewal refused, or been placed on probationary status by any professional licensing body? (This includes any previously successful or currently pending challenge to your licensure, certification or registration.) ☐ YES ☐ NO

  If yes, please explain: _____

- Since submitting your application for Entry Level Treatment Provider have you voluntarily relinquished a license or certification to provide psychotherapy, or voluntarily or involuntarily terminated any mental health staff privileges? ☐ YES ☐ NO

  If yes, please explain: _____

D. Criminal Background Information

- Since submitting your application for Entry Level Treatment Provider have you been convicted of, received a deferred judgment for, or pled nolo contender for any offense involving criminal sexual or violent behavior? ☐ YES ☐ NO

If yes, please explain: _____

- Since submitting your application for Entry Level Treatment Provider have you been arrested, charged or convicted of any criminal offense? ☐ YES ☐ NO

If yes, please explain: _____

- Since submitting your application for Entry Level Treatment Provider have you been convicted of a felony? ☐ YES ☐ NO

If yes, please explain: _____

E. Statement of Understanding

Directions for Applicant:
Please read and sign this form

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 Domestic Violence Offender Treatment Provider List will be used for the following purposes:

1. To conduct a criminal history check and a background investigation.
2. To create and disseminate a list of Approved Domestic Violence Offender Treatment Providers.
3. To create a database of information on the availability of domestic violence offender treatment services in Colorado.
4. 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.
5. 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

6. 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.
7. If any complaints are filed against me, or my services, this application may be re-reviewed.
8. I understand that by applying for approval, I agree to be audited for compliance with the *Standards* when necessary.
1. I understand that any applicant who is denied placement on the Provider List may appeal the Decision. Reference: *Standards,* Appendix D-9 Appeals Process
10. I understand that if my name is included erroneously on the Approved Provider List, the Board may remove it without due process.

Signature of Applicant: _____ Date _____

Name of Applicant (type or print legibly): _____

F. Statements of Compliance

I have read and understand 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 the 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.

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 II

MOVE-UP FROM ENTRY LEVEL TO FULL OPERATING LEVEL FORMS

Reference: *Standards*, Section 9.02

Instructions for the Applicant and the DV Clinical Supervisor

The DVOMB values the expertise, perspectives and feedback of the DV Clinical Supervisor regarding their applicants. Therefore, applicants are required to have a DV Clinical Supervisor involved in their application to the DVOMB for placement on the Approved Provider List.

Note to DV Clinical Supervisors
Please notify the DVOMB in writing if you discontinue your supervision for this applicant, including once he or she becomes a Full Operating Level Provider**.**

DV Clinical Supervisors may require applicants to obtain verification from other supervisors for their previously completed trainings or experiential hours.

Section I. Forms

A. Verification of Trainings
B. Verification of Experiential Hours
C. Verification of Ongoing Supervision
D. Submission of two (2) offender evaluations, treatment plans & contracts
IMPORTANT: 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 20-22)

E. DV Clinical Supervisor Verification

SECTION II

A. Verification of Trainings

Reference the Standards Section 9.01 (J)

Directions for Applicant

*Please list the trainings you attended not including the trainings you submitted to meet the requirements for your **Entry Level Provider** application. Use the title printed on the certificate and indicate the date and the number of hours.* You must complete the required trainings listed below. Training must be obtained from a minimum of 3 different trainers and/or training agencies in order to be exposed to diverse philosophies, styles and theories. *You must submit a **copy** of your certificate of attendance for each training that you attended. (Training certificates will be randomly audited.)*

Required Trainings:

If you completed and submitted the 11 hours of Required Trainings below for your Entry Level application, you may use these trainings a second time for this application. Exceptions may apply if the trainings have changed substantively since you completed the training(s).

(All 11 hours are allocated to the *Evaluation & Assessment* and the *Facilitation & Treatment* categories below)

	Training Date	Hours
☐ DV100	_____	7
☐ DVRNA Training (from DVOMB only)	_____	7
REQUIRED TRAININGS TOTAL:		14

Legal Issues (21 hours)

These training hours must focus on DV issues.

Topics: *Colorado domestic violence and family violence related laws, orders of protection, forensic therapy, confidentiality and duty to warn in domestic violence cases, treatment within the criminal justice system.*

	Training Date	Hours
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____
LEGAL ISSUES TOTAL:		21

A. Verification of Trainings, *continued*

Domestic Violence Victim Issues (35 hours)

These hours must be focused on DV victim issues. You completed 22 of these hours for your Entry Level application. Please document 14 additional hours.

Topics: *Role of victim advocate in domestic violence offender treatment, offender containment and working with a victim advocate, crisis intervention, legal issues including confidentiality, duty to warn, and orders of protection, impact of domestic violence on victims, safety planning, victim dynamics to include obstacles and barriers to leaving abusive relationships, trauma issues.*

	Training Date	**Hours**
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____

DOMESTIC VIOLENCE VICTIM ISSUES TOTAL: 14

Domestic Violence Offender Evaluation and Assessment (49 hours)

These hours must focus on DV offender evaluation and assessment issues. You completed 28 of these hours for your Entry Level application. The balance of the required hours (i.e. **21 hours)** must be obtained from the following topic areas.

Topics: *DV clinical interviewing skills, DV risk assessment, substance abuse screening, use of collateral sources of information, types of abuse, DV offender typologies, cognitive distortions.*

	Training Date	**Hours**
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____

DOMESTIC VIOLENCE OFFENDER EVALUATION & ASSESSMENT TOTAL: 21

SECTION II

A. Verification of Trainings, *continued*

Facilitation and Treatment Planning (49 hours)

You completed 28 of these hours for your Entry Level application. The balance of the required hours (i.e. **21 hours)** must be obtained from the following topic areas.

Topics: *Substance abuse & DV, offender self-management, motivational interviewing, provider role in offender management & containment, forensic psychotherapy, coordination with criminal justice system, offender accountability, recognizing and overcoming offender resistance, offender contracts, ongoing assessment: skills and tools, offender responsivity to treatment, diversity/cultural competency, personality disorders, learning styles.*

	Training Date	**Hours**
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____
Title: _____	_____	_____

FACILITATION AND TREATMENT PLANNING TOTAL: 21

_____

(Applicant Signature) (Date)

B. Verification of Experiential Hours since Applicant's Entry Level Provider approval

Reference: *Standards Section 9.02 (II)(A)*

Directions for Applicant:

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

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

has completed _____clinical experiential hours with domestic violence offenders at
(# of clinical hours)

_____
(Name of agency or agencies)

from _____ to _____.
(month/year) (month/year)

_____ _____
(Domestic Violence Clinical Supervisor's signature) (Date)

C. Verification of Ongoing Clinical Supervision

Reference: *Standards, Section 9.03*

I, _____ do hereby verify that I meet the qualifications of
(DV Clinical Supervisor)

DV Clinical Supervisor as required by the *Standards, Section 9.03*. I verify that _____
(Applicant)

has received the required clinical supervision as per *Standards, Section9.01 (V)*. I further verify that I am providing, and will continue to provide supervision until the Applicant is approved as a Full Operating Level Treatment Provider. If our supervision ends, I will notify the DVOMB in writing of the date the supervision is terminated.

_____ _____
(Domestic Violence Clinical Supervisor's signature) (Date)

SECTION II

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

Standard, 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.

_____
_____
_____
_____
_____
_____
_____
_____

SECTION II

D. Offender Evaluations, Treatment Plans and Treatment Contracts, *continued*

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 20-22)

E. DV Clinical Supervisor Verification

I, _____, do verify that I have reviewed **all** of the above required materials
(DV Clinical Supervisor's Name)

submitted with this application.

_____ _____
(Domestic Violence Clinical Supervisor's signature) (Date)

I acknowledge that my DV Clinical Supervisor may be contacted by the DVOMB or the staff of the DVOMB for the purposes of processing this application. I further acknowledge that all application related correspondence may also be copied to my DV Clinical Supervisor.

(**Applicant, please initial**)_____

COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD
Application for Move-Up from Entry Level to Full Operating Level
June 2017

Assessment of Applicant's Evaluations by DV Clinical Supervisor

This form must be completed by your DV Clinical Supervisor and submitted with each 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