

APPLICANT NAME:

DATE:

**APPLICATION FOR
PROVISIONAL LEVEL
PLACEMENT
via the JUDICIAL RURAL INITIATIVE
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

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Application and Information For Provisional Approval via the Judicial Rural Initiative

Colorado Department of Public Safety
Division of Criminal Justice
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<http://dcj.state.co.us/odvsom>

Who should fill out this application?

This application is for individuals wishing to be placed at the **Provisional Level** on the Approved Provider List of Domestic Violence Offender Treatment Providers (hereafter called the Approved Provider List) via the Judicial Rural Initiative Project. This application is for those individuals who have already submitted the *Intent to Apply for Provisional Provider Listing via the Judicial Rural Initiative*. Applicants must demonstrate that they meet the qualifications of and will comply with standards of practice contained in the *Standards for Treatment with Court Ordered Domestic Violence Offenders* (hereafter *Standards*). **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.

INSTRUCTIONS

1. Follow all instructions carefully – incomplete or incorrect applications may be returned.
2. Use ONLY the forms provided.
3. Submit ONLY the information requested.
4. Submit the required information in the order requested.
5. The Application Review Committee (Committee) meets monthly. New applications are normally reviewed within one to two months of receipt. (Judicial Rural Initiative Project applications are prioritized.) 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 *Standards*, Administrative Policies, Appendix D, III (D) 4.)
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. Please submit all materials on **SINGLE-SIDED COPIES**.
7. **FEES:** The fee for Provisional Level via the Judicial Rural Initiative application is **\$110.50**. A **money order** for **\$110.50** made payable to the “Colorado Department of Public Safety” must be included for the processing of your application.

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

Frequently Asked Questions

Is practice limited for Provisional Level providers applying via the Judicial Rural Initiative?

- Providers who are approved at the Provisional Level can only practice in a designated area of the state. Provisional Level providers are not eligible to practice in other areas of the state.

How can an applicant prepare for completing this application?

- **An 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 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. (Judicial Rural Initiative Project applications are prioritized.) 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)-239-4536.

How will compliance with the Standards be assured?

- Compliance with the *Standards* will be assessed through a Renewal process, possible Quality Assurance Review or on site audits. Mechanisms are in place to receive and investigate complaints through the Department of Regulatory Agencies.

PLEASE REMOVE PAGES 2 - 5 BEFORE RETURNING THIS APPLICATION.

A. Identifying Information

Provisional 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 (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.

#2 AGENCY: _____
Address:

City County Zip

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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 # _____

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- Do you have a current Colorado license or certification to practice psychotherapy?

NO **YES** (A copy of your license or certification 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:

- a. 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 and student interns.

NO **YES**

- 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 Intent to Apply application?

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

B. 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 conduct a criminal history check and a background investigation.
2. To create and disseminate a list of Approved 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. 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.
6. If any complaints are filed against me, or my services, this application may be re-reviewed.
7. I understand that by applying for approval, I agree to be audited for compliance with the *Standards* when necessary.
8. I understand that any applicant who is denied placement on the Provider List may appeal the decision. Reference: *Standards*, Appendix D-9 Appeals Process
9. 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 Provisional Applicant: _____ Date _____

Name of Provisional Applicant (type or print legibly): _____

C. 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 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.

Signature of Provisional Applicant: _____

Date _____

Provisional 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) _____

D. Contact Information for Your References

Please list below names, addresses, and phone numbers of three (3) different references:

These individuals may be interviewed by a DVOMB staff or investigator.

1. The Chief Probation Officer in your judicial district.
2. The advocate who provides victim advocacy for your program.
3. DV Clinical Supervisor

1. Name: _____

Position: _____

Address: _____

Telephone number(s): _____

2. Name: _____

Position: _____

Address: _____

Telephone number(s): _____

3. Name: _____

Position: _____

Address: _____

Telephone number(s): _____

Please attach the following documents:

E. Final Competencies Assessment

Please submit a copy of your final competencies assessment signed by your DV Clinical Supervisor and you.

F. Community Letter of Support

Submit one letter on official letterhead from a local community based domestic violence victim program having them confirm that you have contacted them, inquired about their program and services and confirming that you are working, or willing to work, collaboratively with them on community-based DV issues.

G. Letter from Victim Advocate

Submit one letter from your victim advocate on official letterhead verifying that he or she is currently (or will be once you are approved) providing victim advocacy for your cases per the *Standards, Section 7.02*

H. 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.

I. Verification of Supervision

Directions for Applicant:

Please have your Domestic Violence Clinical Supervisor verify your mentoring by completing this form.

Please provide name of agency where experience was gained. _____

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

_____, and I have measured his/her competencies as demonstrated on
(Applicant)

this Competencies Form. I further document that I believe this applicant is appropriate for Provisional Approval.

(DV Clinical Supervisor's signature) _____ Date

J. Verification of Ongoing Clinical Supervision

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 further verify that I am providing and will continue to provide supervision for _____ once approved, as required
(Provisional Applicant)

by the *Standards*, Section 9.07 (V) for *Judicial Rural Initiative Provisional Approval*. If our supervision ends, I will notify the DVOMB in writing of the date the supervision is terminated.

(DV Clinical Supervisor's signature) _____ Date

K. Verification of Training Hours

Reference: Judicial Rural Initiative Project Policies, revised March 2012.

Directions for Applicant:

*Please list the trainings you attended using the title printed on the certificate and indicate the date and the number of hours. You must submit a **copy** of your certificate of attendance for each training you attended. Training certificates will be randomly audited.*

Required Trainings

	<u>Training Date</u>	<u>Hours</u>
<input type="checkbox"/> 7 Hour DVOMB Current Standards Training	_____	7
<input type="checkbox"/> DVRNA Training (from DVOMB only)	_____	4
<input type="checkbox"/> Victim issues/dynamics	_____	5
<input type="checkbox"/> Other DV specific trainings	_____	4

REQUIRED TRAININGS TOTAL: 20

(Applicant signature)

(Date)

L. Verification of Ongoing Co-Facilitation

Reference the Standards, Section 9.01

Directions for Applicant:

Please have your Full Operating Level Treatment Provider or DV Clinical Supervisor complete this form. 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 client face-to-face sessions must be co-facilitated with an Approved Provider. This includes individual sessions, group sessions and evaluations. §16-11.8-104 C.R.S.

I, _____, do hereby verify that I am co-
(Approved Full Operating Level DV Treatment Provider or DV Clinical Supervisor)

facilitating all domestic violence offender treatment and evaluations as required by *Standards*, Section 9.07 (V),

with _____.
(Provisional 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 Full Operating Level DV Treatment Provider or DV Clinical Supervisor Signature) (Date)

M. Offender Evaluations, Treatment Plans & 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 17-19).

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 _____

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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_

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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

N. Supervisor's Review

Please have your DV Clinical supervisor complete this form:

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

(Domestic Violence Clinical Supervisor's signature)

(Date)

Please submit all materials to:

**DVOMB
Carolina Thomasson
Standards Coordinator
700 Kipling Street, Suite 1000
Denver, Colorado 80215**

Thank you!