

RE-APPLICATION FOR RE-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)
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<http://dcj.dvomb.state.co.us>

February 2017

COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD
RE-APPLICATION FOR RE-PLACEMENT PACKET –August 2016

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Instructions for Re-Application for Re-Placement on the Approved Provider List

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.state.co.us/odvsom>

This re-application is for **previously approved** Domestic Violence Treatment Providers wishing to be re-listed on the Domestic Violence Offender Management Board's Approved Provider List (hereafter called the *Provider List*). Applicants must demonstrate compliance with the Domestic Violence Offender Management Board's current standards of practice contained in *Standards for Treatment with Court Ordered Domestic Violence Offenders* (hereafter referred to as the *Standards*).

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

INSTRUCTIONS

1. Identify if you were removed from the Approved Provider List Voluntarily or Involuntarily.
2. All Re-Applicants must complete **A – K** of this Re-Application, and,
3. Re-Applicants who were **Voluntarily Removed** must complete **Section J-1 and K-1**.
4. Re-Applicants who were **Involuntarily Removed** must complete **Sections J-2 and K-2**.
5. Use only the forms provided.
6. Submit only the information requested.
7. Submit the required information in the order requested.
8. Follow all instructions carefully—incomplete or incorrect applications may be returned.
9. Please do not use staples, paper clips, binders, sheet protectors or other materials. Please submit all materials on **SINGLE-SIDED COPIES**.

INSTRUCTIONS CONTINUED

10. A money order made payable to “Colorado Department of Public Safety” must be included with the Re-Application form (*see page 8 of this packet for applicable fee*).
11. It is the re-applicant’s responsibility to obtain, review, and adhere to the current publication of the Standards since the Standards are revised periodically.
12. Re-applicants will be notified in writing that our office has received their Application packet and again in writing once the packet has been reviewed.
13. The ARC will review your documentation and determine whether your placement will be granted or denied.

Frequently Asked Questions (FAQ)

Why is the process called a Re-Application and not a renewal similar to the process from the Department of Regulatory Agencies?

The Re-Application involves a review of your practice, program, and clinical skills. Your documentation will be reviewed to determine whether your placement will be granted or denied. A renewal generally does not require any of these types of documentation. The DVOMB Biennial Renewal is for Providers who are already listed on our Approved Provider List who wish to maintain their Placement on the Approved Provider List.

What is the difference between “voluntary” and “involuntary” Removal from the Approved Provider List?

Involuntary Removal from the Approved Provider List:

If you were removed from the Approved Provider List due to Standards Violations or DORA Discipline, your removal from the List was “involuntary”. Please note specific additional requirements related to your Removal may be required by the Application Review Committee, C.R.S. 16-11.8-103 (4) III (D). You will be notified in writing from the Application Review Committee of any additional requirements after the initial review of your Re-application.

Voluntary Removal from the Approved Provider List:

If you were removed from the Approved Provider List for reasons such as moving out of state, failing to submit your Biennial Renewal by the DVOMB deadline, or retiring and then deciding to return to the field, then your Removal from the List was “voluntary”.

Why must I be listed at the Entry Level if I have been Involuntarily Removed from the Provider List?

The Standards, Appendix D (F) (3) state: “...Providers who were removed from the Provider List due to Standards violations and/or DORA discipline shall submit a *Re-Application for Re-Placement Application* and if approved, shall provide treatment at Entry Level for at least six months before being permitted to apply for Full Operating Level.”

What should a Provider do upon completion of this Re-Application?

When completed, send the Re-Application in hard copy to: **Domestic Violence Offender Management Board/Division of Criminal Justice, 700 Kipling Street, Suite 1000, Lakewood, CO 80215.**

PLEASE KEEP A COPY OF YOUR COMPLETED APPLICATION FOR YOUR RECORDS.

How long will the entire re-application review process take?

Please note the re-application review process could take several months. You can expedite the process by submitting all of your Re-Application materials according to the instructions.

What are my additional responsibilities as an Applicant?

It is your responsibility to notify the Board, in writing, of any changes to your name, title, address, phone number, program name, program materials and if you have added any additional treatment locations. It is your responsibility to provide information to the Board, in writing if you have added a license, if you have been disciplined by the Department of Regulatory Agencies, if you have had your license revoked, or if there is any other change in your professional standing.

A. Statement of Understanding Form

What Will Be Done With Information I Provide on the Re-Application?

I understand that the information I have submitted for this Re-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 Re-Application materials will become public record of the Division of Criminal Justice and may be subject to the Open Records 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 Re-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, my file may be re-reviewed by the Application Review Committee of the Domestic Violence Offender Management Board.

Signature of Re-Applicant: _____ Date _____

Print Name: (type or print legibly): _____

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B. Re-Application Fee

Re-Applicant Name _____

Re-Applicant Phone Number _____

Please attach the following:

Provisional Level: **\$150**

Entry Level: **\$200**

Full Operating Level and DV Clinical Supervisor: **\$300**

The correct amount in the form of a **money order** is required to cover the cost of your Re-Application. Please make the money order payable to “Colorado Department of Public Safety” (Do not use acronym). ***Personal checks will not be accepted.***

For office use only

Date received: _____ Money Order enclosed _____

Pursuant to C.R.S. 16-11.8-104 (2) (a) (b):

(a) The board shall require any person who applies for placement, including any person who applies for continued placement, on the approved list developed pursuant to Section 16-11.8-103 (4) to submit to a current background investigation that goes beyond the scope of the criminal history record check described in section 16-11.8-103 (4) (b) (III) (A). In conducting the current background investigation, the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant’s fitness to provide domestic violence offender treatment evaluation or treatment services pursuant to this article.

(b) The board may assess a fee to a person who applies for initial placement or renewed placement on the approved provider list not to exceed three hundred dollars per application to cover the costs of conducting the current background investigation required by this subsection (2) and the costs associated with the initial application review and the renewal process pursuant to section 16-11.8-103 (4) (b) (III) and other costs associated with administering the program. All moneys collected pursuant to this paragraph (b) shall be transmitted to the state treasurer, who shall credit the same to the domestic violence offender treatment provider fund, which fund is hereby created and referred to in this paragraph (b) as the “fund”. The moneys in the fund shall be subject to annual appropriation by the general assembly for the direct and indirect costs associated with the current background investigation required by this subsection (2) and the application review and renewal process and other costs associated with administering the program. Any moneys in the fund not expended for the purpose of this subsection (2) may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year shall in the fund and shall not be credited or transferred to the general fund or another fund.

C. Department of Regulatory Agencies (DORA) Verification Form

(To be completed by Re-Applicant)

PLEASE INCLUDE THIS PAGE IN YOUR RE-APPLICATION PACKET

PRINT NAME	Last	First	Middle	(Maiden Name)
------------	------	-------	--------	---------------

AGENCY 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.

Signature

Date

D. Background and Identifying Information Form

(This information will be used by staff or an investigator to conduct a criminal history check, background investigation, and to document qualifications.)

Re-Applicant Name: _____

(You must apply as an individual, not as a program or partnership.)

Maiden Name/other names used: _____

Salutation: (Mr., Ms., etc). _____

Reason for Removal from DVOMB List:

☐ Voluntary ☐ Involuntary (Ref. Page 4 of Re-application)

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.

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.

.....

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#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 # _____

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- 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:

- 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 last application?

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

E. Statements of Compliance Forms

1. Report of Any Practice that Conflicts or Varies from the *Standards*

In the space below, please identify any aspect of your practice in which you are unable to comply with the *Standards*. Describe in detail your plan or steps being taken to bring your practice into compliance. Some recent examples of reported variance with the *Standards* have been: (1) rural providers not attaining the required types and levels of supervision or (2) providers for specific populations developing treatment that is not in accordance with the *Standards*.

I am in complete compliance with the *Standards*.

☐ YES

☐ NO

If you answered no, please explain below:

(Please initial) _____

2. Research Statement of Compliance

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

(Please initial) _____

F. Offender Evaluations, Treatment Plans and Contracts

Standards, 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?

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

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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 note: Evaluations must have been completed within six (6) months prior to the date of this Re-Application and co-signed/reviewed by either:

- a) Your DV Clinical Supervisor if you were involuntarily removed from the Provider List or if you are voluntarily applying at the Entry Level, or
- b) Your Peer Consultant if you were voluntarily removed and are re-applying at the Full Operating Level.

G. Letter from Victim Advocate

Ask your victim advocate to submit a letter directly to our office verifying that he/she is currently (or will be once you are approved) providing victim advocacy for you per the *Standards, Section 7.02*

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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 _____

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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_____

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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

H. Contact Information for Your References

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

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

1. Your Domestic Violence Clinical Supervisor OR a peer consultant;
2. The advocate who provides (or will provide) victim advocacy for your program; and,
3. The name of the Chief Probation Officer in the jurisdiction in which you wish to provide services.

1. Name: _____

Position: _____

Address: _____

Office phone: _____ Cell Phone: _____

E-Mail Address: _____

2 Name: _____

Position: _____

Address: _____

Office phone: _____ Cell Phone: _____

E-Mail Address: _____

3. Probation Officer Name (also identify judicial district, state or private probation):

Address: _____

Office phone: _____ Cell Phone: _____

E-Mail Address: _____

I. Verification of Ongoing Co-Facilitation Form

Court ordered domestic violence offender treatment may only be provided by an Approved Provider. Therefore, all client face-to-face sessions must be co-facilitated--this includes individual sessions, group sessions, and evaluations. §16-11.8-104 C.R.S.

Re-Applicants: Please have the Approved Provider who is co-facilitating your work complete this form *OR* if you are not currently working in domestic violence offender treatment, complete the bottom portion of this form.

I, _____ do hereby verify that I am co-facilitating all
(Approved Domestic Violence Treatment Provider) [as required by Section 9.0]

domestic violence offender treatment, as identified above, with the following re-applicant:

(Re-Applicant)

I further verify that I will continue to provide co-facilitation for this re-applicant during the entire re-application process which I understand may continue for several months or more. If I need to discontinue my co-facilitation, I will notify the DVOMB office at the address listed below.

(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

I, _____ do hereby verify that I am not currently working in the
(Re-Applicant)

domestic violence offender treatment field. If I do 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.

(Approved Domestic Violence Treatment Provider's Signature)

Date

J-1.Verification of Trainings for those Re-Applicants who were Voluntarily Removed from the Approved Provider List:

Reference the Standards Section 9.01 III

Directions for Re-Applicant who has been voluntarily removed from the Provider List as defined in Section FAQ, page 6 of this Re-Application:

- You must submit 28 hours of continuing education (from 3 different trainers and/or 3 different training agencies to be exposed to diverse philosophies, styles and theories) obtained within the past two years of the date of this RE-Application; 4 out of 28 hours must be in victim issues.
- In addition, you must have completed the DVRNA and the 7 Hour DVOMB Current Standards Training.

28 hours Training Title

Training Hours

Training Date

DVRNA (from a DVOMB trainer only)

☐ 4 Hours Date:_____

7 Hour DVOMB Current Standards Training

☐ 7 Hours Date:_____

(Re-Applicant Signature)

Date

J-2.Verification of Trainings for those Re-Applicants who were Involuntarily Removed from the Approved Provider List:

Reference the Standards Section 9.01 III

Directions for Re-Applicant who has been involuntarily removed from the Provider List as defined in Section FAQ, page 6 of this Re-Application.

- You must submit 28 hours of continuing education (from 3 different trainers and/or 3 training agencies to be exposed to diverse philosophies, styles and theories) obtained within the past two years of the date of this RE-Application; 4 out of 28 hours must be in victim issues.
- In addition, you must have completed the DVRNA and the 7 Hour DVOMB Current Standards Training, and any other specific requirements related to your Removal as determined by the Application Review Committee. C.R.S. 16-11.8-103 (4) III (D).

(Please note any other specific requirements related to your Removal as determined by the Application Review Committee will be identified in writing after the Committee's first initial review of your Re-application.)

28 Hours Training Title

Training Hours

Training Date

DVRNA from DVOMB

☐ 4 Hours Date: _____

7 Hour DVOMB Current Standards Training

☐ 7 Hours Date: _____

(Re-Applicant Signature)

Date

K-1 Verification of Ongoing Peer or Clinical Supervision Form

(FOR VOLUNTARILY REMOVED PROVIDERS)

Reference the *Standards*, Sections 9.0.

Please complete section I, section II, or both as applicable.

I. SUPERVISOR OF RE-APPLICANT

I, _____ do hereby verify that I meet the qualifications of DV
Domestic Violence Clinical Supervisor

Clinical Supervisor as required by the *Standards* Section 9.03. I further verify that I am providing supervision for
_____ as required by the *Standards* Section 9.04
Re-Applicant

and that this supervision began on _____. This supervision consists of _____ hours
Date

each month of group and _____ hours each month of individual supervision per the *Standards* Section 9.19

If this supervision includes electronic modes, please indicate type, how, when and what type of review used as well
as how and when face-to-face supervision occurs _____

(Signature of Domestic Violence Clinical Supervisor)

Date

II. PEER CONSULTATION with RE-APPLICANT

I, _____ do hereby verify that I engaged in peer
Re-Applicant

Consultation with _____
Name(s) of Peer Consultant (s)
during the following time period _____.

K-2 Verification of Ongoing Clinical Supervision Form

(FOR INVOLUNTARILY REMOVED PROVIDERS)

Reference the *Standards*, Sections 9.0.

SUPERVISOR OF ENTRY LEVEL RE-APPLICANT

I, _____ do hereby verify that I meet the qualifications of DV
Domestic Violence Clinical Supervisor

Clinical Supervisor as required by the *Standards* Section 9.03. I further verify that I am providing supervision for

_____ as required by the *Standards* Section 9.04
Re-Applicant

and that this supervision began on _____. This supervision consists of _____ hours
Date

each month of group and _____ hours each month of individual supervision per the *Standards* Section 9.19

If this supervision includes electronic modes, please indicate type, how, when and what type of review used as well
as how and when face-to-face supervision occurs _____

(Signature of Domestic Violence Clinical Supervisor)

Date