APPLICANT NAME:

DATE:

APPLICATION
FOR
SPECIFIC OFFENDER POPULATIONS

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

Please submit all materials on SINGLE-SIDED COPIES only.

REQUIREMENTS

A. Qualifications for Treating Domestic Violence Female Offenders

1. Experiential hours
2. Supervision
3. Statement of Compliance
4. Training hours – submit certificates for **14** hours
   Standards, Section 10.03, "*If an approved provider identifies a specific offender population as a focus of treatment, the provider shall be required to have a minimum of 14 hours of specialized training specific to that population. The 14 hours is in addition to training required under Standards 9.02 and 9.03.*
5. 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 female offenders.
   a. 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).
   b. 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 Evaluation by DV Clinical Supervisor* form for each evaluation (See Pages 3 - 5)

B. Qualifications for Treating Domestic Violence Same Sex Offenders

1. Experiential hours
2. Supervision
3. Statement of Compliance
4. Training hours – submit certificates for **14** hours
   Standards, Section 10.03, "*If an approved provider identifies a specific offender population as a focus of treatment, the provider shall be required to have a minimum of 14 hours of specialized training specific to that population. The 14 hours is in addition to training required under Standards 9.02 and 9.03.*"
5. 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 same-sex offenders.
   a. 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).
   b. 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 3-5).

Assessment of Applicant's Evaluations by DV Clinical Supervisor

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

Applicant/Supervisee Name:_____

DV Clinical Supervisor Name:_____

Today's Date:_____

ALL ELEMENTS BELOW ARE REQUIRED

STANDARD

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

4.08 Identify minimum mandatory source of information?
External sources of information:
Criminal Hx/other CJ info _____ _____
Police report _____ _____
Victim Impact Statement or victim input (if avail)_____ _____
Previous evaluations_____ _____
Available collaterals_____ _____
PSI if available _____ _____
Internal sources of information:
Clinical interview_____ _____
Risk assessments_____ _____
Required Assessment Instruments (used and scored correctly?):
2nd risk assessment_____ _____
Substance Abuse Screening Instruments_____ _____
DVRNA_____ _____
Required in Clinical Interview:
Psychosocial History_____ _____
Mental health history_____ _____
Cognitive screen_____ _____
Substance use history_____ _____
Relationship history (DV dynamics)_____ _____

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

Did the evaluation identify the following?
Specific victim safety issues_____ _____
Risk of re-offense or abuse_____ _____
Criminogenic factors & needs_____ _____
Potential destabilizing factors_____ _____
Motivation/responsivity/amenability to tx_____ _____
Offender accountability_____ _____

Strengths & Weaknesses_____ _____
Initial level of placement in treatment (based on DVRNA) _____

_____ _____
Initial tx recommendations_____ _____
Was the evaluation co-signed by an approved DVOMB Provider?_____ _____

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

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

REQUIRED EVALUATIONS COMPETENCIES

Applicant demonstrates the following:

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

_____

_____

_____

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

_____

_____

3. All required components of 4.0_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

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

_____

Does the plan identify containment goals?_____

_____

Does the plan promote risk reductions?_____

_____

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

_____

DV CLINICAL SUPERVISOR'S NOTES:

Evaluations accepted.

Treatment Plans accepted.

Treatment Contract accepted.

Accepted with comments: please attach any additional comments.

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

_____

DV Clinical Supervisor Signature Date

Background and Identifying Information

Date: ____________________________

Applicant Name: ____

Credentials (LCSW, CAC III, etc.): ____

Phone number: ____

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

E-mail: ____
□ DO NOT PUBLISH my email on the Approved Provider List.

******Requested information is public record; for safety reasons, do not use home information. However, if your primary contact information is your home, please indicate below. ******

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 # ____

- 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.

____

____

A.1. Female Offender Population Experiential Hours

Directions for Applicant:
Reference Standards, Section 10.04 and Appendix B (II)

Providers or applicants applying to work with female offenders as defined in Section 10.0 and Appendix B regarding treatment in a specific offender population, the provider shall have 50 face-to-face client contact hours with females who have domestic violence offenses or other offenses involving criminal justice system required treatment. If the applicant does not have 50 face-to-face client contact hours with convicted female domestic violence offenders, the applicant must document relevant expertise with treatment of females and detail how that expertise was gained.

Please attach your documentation to this packet.

I, _____ do hereby verify that
(Name of DV Treatment Provider, DV Clinical Supervisor or other relevant professional)

_____completed the
(Name of Applicant)

Experiential Hours requirements contained in *Standards*, *Specific Offender Population, Section 10.04 at*

_____.
(Name of agency where experience was gained)

_____
(Signature of DV Treatment Provider, DV Clinical Supervisor or other relevant professional)

_____
(Date)

A2. Female Offender Population Statement of Compliance

I have read and understand Section 10.0 Specific Offender Populations of the *Standards for Treatment with Court Ordered Domestic Violence Offenders* and Appendix B in their entirety. My program is in compliance with, and I 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.

I understand that, if approved, I must have continued supervision (if I am Entry Level) or peer consultation (if I am Full Operating Level) regarding female offenders per Section 10.05.

Signature of Applicant: _____

Date _____

B. 1. Same Sex Offender Experiential Hours

Directions for Applicant:
Reference Standards, Section 10.04, 10.08 and Appendix B (1)

Providers or applicants applying to work with same sex partner offenders as defined in Section 10.04, 10.08 and Appendix B shall have 50 face-to-face client contact hours with offenders involved in domestic violence offenses or other required treatment in the criminal justice system. If the applicant does not have 50 face-to-face client contact hours with convicted same sex partner domestic violence offenders, the applicant must document relevant expertise with treatment of this population and detail how that expertise was gained.

Please attach your documentation to this packet.

I, _____ do hereby verify that
(Name of DV Treatment Provider, DV Clinical Supervisor or other relevant professional)

_____completed the
(Name of Applicant)

Experiential Hours requirements contained in *Standards*, *Specific Offender Population, Section 10.04 at*

_____.
(Name of agency where experience was gained)

_____
(Signature of DV Treatment Provider, DV Clinical Supervisor or other relevant professional)

_____
(Date)

B. 2. If there was a community need for you to provide services to a Same Sex Partner Offender prior to Board approval, as per Section 10.08, please provide the following information regarding your supervision:

R*eference Standards, Section 10.08 and Appendix B*

I provided supervision to _____ in the interim, as per Section 10.08, in
(Applicant Name)
order for him/her to provide services to Same Sex Partner offender clients.

Supervisor Name: _____

Agency Name:_____

Location:_____

_____
(Signature of Full Operating Level DV Treatment Provider or DV Clinical Supervisor) Date

B 3. Same Sex Offender Statement of Compliance

I have read and understand Section 10.0 Specific Offender Populations of the *Standards for Treatment with Court Ordered Domestic Violence Offenders* and Appendix B in their entirety. My program is in compliance with, and I 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.

I understand that, if approved, I must have continued supervision (if I am Entry Level) or peer consultation (if I am Full Operating Level) regarding same sex partner offenders as per Section 10.05.

Signature of Applicant: _____

Date _____