INTENT TO APPLY FOR PROVISIONAL PROVIDER LISTING VIA THE JUDICIAL RURAL INITIATIVE

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

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Instructions and Information for Intent to Apply for Provisional Provider Listing via the Judicial Rural Initiative

Colorado Department of Public Safety
Division of Criminal Justice
700 Kipling Street, Suite 1000
Denver, CO 80215
Tel: (303) 239-4528 or 1-800-201-1325 (in Colorado only)
Fax (303) 239-4491
http://dcj.state.co.us/odvsom

Who should fill out this application?

This application is only for:

1. Individuals who intend to apply for Provisional Provider Listing on the Domestic Violence Offender Treatment Board's (hereafter DVOMB) Approved Provider List via the Judicial Rural Initiative as described in the DVOMB's *Judicial Rural Initiative Project Policies* revised April 2012.

Applicants must demonstrate that they meet the qualifications of and will comply with standards of practice contained in the DVOMB's *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. 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 within one to two months of receipt. (Judicial Rural Initiative projects are prioritized.) The Committee will then notify the applicant of any missing documentation. Applicants shall have one year from the submission of the Intent to Apply to submit the final application for Committee review.
6. PLEASE DO NOT use staples, paper clips, binders, sheet protectors or other materials. Please submit all materials on SINGLE-SIDED COPIES.
7. Applicants must submit one set of fingerprints for the purpose of a background check of their criminal history. To do so, go to the Identgo website here: https://uenroll.identogo.com/workflows/25YGT4. Enter your personal information and schedule an appointment at one of the approved fingerprint center located near you. You will receive confirmation of your appointment. Payment is made at the time of fingerprinting for a total of $49.50. Business checks, credit cards, and money orders are accepted. Personal checks will NOT be accepted. You can also schedule an appointment by phone by calling the toll free number 1-(844) 539-5539. When calling, you must supply the DVOMB Service Code: *25YGT4*. If you have questions, please email Adrienne Corday, Program Assistant to the DVOMB at adrienne.corday@state.co.us.

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

A. Background and Identifying Information

Information provided will be used by staff to conduct a criminal history check, background investigation and to document qualifications.

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: _____

Social Security Number: _____
(Required by federal law)

Business Name if applicable: _____

PRIMARY CONTACT INFORMATION (*requested information below is public record. For safety reasons, do not use home information):*

_____
Street Address City State Zip

Telephone: _____ Fax: _____ E-mail: _____

DVOMB APPROVED CLINICAL SUPERVISOR CONTACT INFORMATION:

_____
Name

_____
Street Address City State Zip

Telephone:_____Fax:_____E-mail:_____

*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. (**Please initial**)_____
_____

B. Request for Variance

This is a written statement from you requesting a variance under the Judicial Rural Initiative Project. (Please attach)

C. Supervision Plan & Competencies

This is a written agreement between you and your DV Clinical Supervisor. This plan is based on the supervisor's initial assessment of your competencies as a treatment provider.

Please ensure that both you and your supervisor understand the requirements contained in the documents entitled the form entitled *Required Applicant Competencies via the Judicial Rural Initiative* and the *Judicial Rural Initiative Project Policies, revised April 2012*.

Please attach:

i. The completed Supervision Plan as prescribed by the *Judicial Rural Initiative Project Policies* and signed by you and your supervisor
ii. The completed initial *Required Applicant Competencies via the Judicial Rural Initiative* form

D. Confirmation Letter

This is a letter from the Chief Probation Officer of the judicial district confirming that you are working with them under the Judicial Rural Initiative project. (Please attach or ensure the submission of this letter under separate cover.)

E. Verification of Ongoing Clinical Supervision and Ongoing Co-facilitation

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

DV Clinical Supervisor as required by the *Standards,* Section 9.03 and that I have had training in providing supervision under the Judicial Rural Initiative Project. I further verify that I am providing and

will continue to provide supervision for _____ as required in the
(Applicant)

Judicial Rural Initiative Project Policies, revised April 2012. If our supervision ends, I will notify the DVOMB in writing of the date the supervision is terminated.

> *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.

Therefore, I also verify that I am co-facilitating as required by *Standards,* Section 9.07 (V) **all** domestic violence offender treatment with the above named applicant **and**/**or** I am ensuring that a Full Operating Level Approved Domestic Violence Treatment Provider is co-facilitating when I am not present. I further verify that I will continue to ensure co-facilitation for this applicant during their entire training and application process. If I need to discontinue my co-facilitation, I will notify the DVOMB office at 700 Kipling Street, Suite 1000, Denver, CO 80215.

_____ _____
(Applicant signature) Date

_____
(DV Clinical Supervisor's signature) Date

F. DORA Verification

DEPARTMENT OF REGULATORY AGENCIES (DORA)
VERIFICATION FORM

****

PRINT NAME Last First Middle (Maiden Name)

ADDRESS Street City State Zip

****

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

Signature Date

G. 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) _____

- Have you practiced psychotherapy without a license in any other state? ☐ YES ☐ NO
  If yes, please list those states _____

- Have you ever been licensed or certified to practice psychotherapy in any other states? ☐ YES ☐ NO
  If yes, please list those states and your license

_____

- 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:_____

- Have you ever 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: _____

- Have you ever had a license or certification revoked, suspended, renewal refused, or been placed on probationary status by any professional licensing body? ☐ YES ☐ NO
  If yes, please explain: _____

- Have you ever 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: _____

H. Criminal Background Information

- Have you ever been convicted of, received a deferred judgment for, or pled nolo contender to any offense involving criminal sexual or violent behavior? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

_____

_____

- Have you ever been arrested, charged or convicted of any criminal offense? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

_____

- Have you ever been convicted of a felony? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

_____

I. Education

Reference the Standards 9.01 1 (A)

Applicant must have a Bachelor's Degree or higher in a human services area of study. The degree must be obtained from a college or university accredited by an agency recognized by the U.S. Department of Education.

Directions for Applicant:

Submit a copy of your transcripts in addition to completing this form. An unofficial copy is acceptable.

Applicant Name _____

Degree _____ Major _____

College or University _____

Please submit all materials to:

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

Thank you!