APPLICANT NAME:

DATE:

APPLICATION FOR PROVISIONAL 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

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Application and Information For Provisional Approval

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). 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* published by the Domestic Violence Offender Management Board (hereafter referred to as the *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.

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 within one to two months of receipt. (Provisional applications will be 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 administrative policy on time limits, April 2006, in Appendix D of the *Standards*.)
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.
8. A money order for **$110.50** made payable to **Colorado Department of Public Safety** must be included for the processing of your application.

Frequently Asked Questions

Is practice limited for Provisional Level providers?

- 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. (Provisional 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 I find additional copies of the Standards and application forms?

- 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 - 4 BEFORE SUBMITTING 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: _______________________________

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.

- -

#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 # ____

SECTION I

B. 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? (This includes any previously successful or currently pending challenge to your licensure, certification or registration.) ☐ 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: _____

SECTION I

C. 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

SECTION I

D. 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: _____

_____

_____

_____

E (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

F. 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): _____

SECTION I

G. 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) _____

H. Education

Reference the Standards 9.01 1 (A)

Provisional 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 Provisional Applicant:

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

Provisional Applicant Name _____

Degree _____ Major _____

College or University _____

A. Community Letters of Support

All Provisional Level applicants must submit at least five community letters of support documenting and identifying specific community need for offender treatment that cannot be met by existing providers:

1. Letter from a local community based domestic violence victim program. (i.e., a local domestic violence shelter or non-governmental victim resource program. This is not a letter from your victim advocate.)

2. Letter from a criminal justice supervision agency, primary referral resource (i.e., judge, state probation, private probation).

3. Letters from other individuals representing agencies involved in offender containment (i.e., district attorney's office, public defender's office, mental health services agency, etc.)

A NOTE TO THE PERSON PROVIDING THE LETTER OF SUPPORT: This letter of support should address the issues specified below. Also, please summarize additional issues that you would like to convey to the Application Review Committee of the Board. These responses must be submitted on official letterhead directly to the DVOMB at 700 Kipling St. Suite 1000, Denver, Co. 80215

1. How long have you known this Provisional Applicant?

2. What is the context in which the agency or entity is familiar with the Provisional Applicant?

3. Please identify the specific need for offender treatment that cannot currently be met in your community. For example, there are no existing approved providers, or there are no existing providers that can provide treatment in Spanish, etc.

4. Please identify the applicant by name in your letter.

5. Please include your title, your place of work, and the relevance of your work to domestic violence offender containment.

THANK YOU!

SECTION II

B. Verification of Experiential & Supervisory Hours

Reference the Standards Section 9.07

Please have your Domestic Violence Clinical Supervisor verify these hours and complete this form. DV Clinical Supervisors may require you to provide verification and/or obtain additional verification from former or adjunct supervisors.

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

_____ has completed all of the required experiential hours
(Applicant)

and received all of the required clinical supervision below as per the *Standards, Section 9.07 (V)*.

_____ _____
(DV Clinical Supervisor's signature) Date

****

2. 300 Hours General Experiential Counseling. These hours shall be face-to-face client contact hours providing evaluations and/or individual and/or group counseling sessions concurrent with 15 hours of general clinical supervision for the 300 hours of general experiential counseling hours, *Standards, Section 9.07 (III) (A).*

If the applicant has a master's degree in counseling or a CAC II or higher, a copy of the transcript verifying an internship or a copy of the CAC certification will satisfy this requirement.

_____
(*Name of agency where experience was gained*)

****

3. Bachelor's degree applicants: 108 hours of face-to-face client contact hours working with domestic violence offenders directly observed by a Full Operating Level Provider or DV Clinical Supervisor.

or

Master's Degree applicants with a minimum of 1,000 hours post graduate counseling experience: 54 hours of face-to-face client contact hours working with domestic violence offenders directly observed by a Full Operating Level Provider or DV Clinical Supervisor.

These hours shall be in addition to the 300 general experiential hours, *Standards, Section 9.07 (III), (B)*. Applicants are required to have DV clinical supervision for a minimum of 1 hour per month for up to 10 client contact hours, and 2 hours per month for 10 or more client contact hours or additional supervision as determined by the DV Clinical Supervisor with an additional hour per month on clinical preparation and clinical review of these experiential hours.

_____
(*Name of agency where experience was gained*)

SECTION II

C. Verification of Training Hours

Reference the Standards Section 9.07 (IV)

Directions for Applicant

Masters degree applicants:
35 hours of documented training specifically related to domestic violence evaluation and treatment methods are required.

Bachelor's degree applicants:
70 hours of documented training specifically related to domestic violence evaluation and treatment methods are required.

Please list the trainings you attended using 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 you attended. Training certificates will be randomly audited.*

Required Trainings
(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

Basic Counseling Skills: Bachelor degree applicants (35 hours required)
Applicants with a masters degree in a counseling related field, or Certified Addictions Counselor II, or higher do **not** need to document these training hours. Topics: c*ounseling techniques, individual and group skills, treatment planning, group dynamics.*

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

BASIC COUNSELING TOTAL: 35

C. Verification of Trainings (cont.)

Domestic Violence Victim Issues (14 hours)

These hours must focus on DV victim issues.

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: _____	_____	_____
Title: _____	_____	_____

DOMESTIC VIOLENCE VICTIM ISSUES TOTAL: 14

Domestic Violence Offender Evaluation and Assessment (14 hours)

These hours must focus on DV offender evaluation and assessment issues.

5 hours of this category are fulfilled under the **Required Training** category above. The balance of the required hours (i.e. **9 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, criminal thinking errors, criminogenic needs.*

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

DOMESTIC VIOLENCE OFFENDER EVALUATION & ASSESSMENT TOTAL: 14

C. Verification of Trainings (cont.)

Facilitation and Treatment Planning (7 hours)

6 hours of this category are fulfilled under the **Required Training** category above. The balance of the required hours (i.e. **1 hour)** must be obtained from the following topic areas.

Topics: *Substance abuse & DV, offender self management, motivational interviewing, provider role in offender 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, learning styles, personality disorders, levels & competencies*.

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

FACILITATION AND TREATMENT PLANNING TOTAL: 7

* *

TOTAL TRAINING HOURS SHOULD EQUAL**:**

☐ **35** for Master's Degree applicants, *or*

☐ **70** for Bachelor's Degree applicants

TOTAL TRAINING HOURS: _____

_____

(Applicant Signature) (Date)

C. Verification of Trainings (cont.)

Please have your DV clinical supervisor review your trainings & certificates and verify by completing this form.

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

_____ 's training certificates and
(Applicant)

verify that the applicant has received either

- ☐ 35 hours for master's degree, *or*
- ☐ 70 hours for bachelor's degree

of documented training specifically related to domestic violence evaluation and treatment methods.

_____

(DV Clinical Supervisor's signature) (Date)

D. 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 *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)

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**)_____

E. Verification of Ongoing Co-Facilitation

Reference the Standards, Section 9.07

Directions for Applicant:
Please complete either the top half **or** the bottom half of 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 a Full Operating Level Treatment Provider or a DV Clinical Supervisor. This includes individual sessions, group sessions and evaluations. §16-11.8-104 C.R.S.

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

all domestic violence offender treatment and evaluation, as required by *Standards, Section 9.07(III)* with

_____.
(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.

_____
(Full Operating Level Treatment Provider or DV Clinical Supervisor 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 providing
(Applicant)
treatment or evaluations to convicted domestic violence offenders. 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.

_____
(Applicant's Signature) (Date)

F. Letter from Victim Advocate

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

G. 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.

H. Supervisor Verification

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)

I. Evaluations, Treatment Plans, Treatment Contract & DV Assessments of Applicant's Evaluations

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?

☐ 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.

_____
_____
_____
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_____
_____
_____

I. Evaluations, Treatment Plans, Treatment Contract & DV Assessments of Applicant's Evaluations *(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 27-29)

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