COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD (DVOMB)

2019 BIENNIAL RENEWAL FORM

All Domestic Violence Management Board Approved Providers (including those who are "Not Currently Practicing") are required to renew their placement on the Approved Provider List biennially.

Please submit all required materials by the
July 31, 2019 *deadline to:*
Carolina Thomasson, DVOMB Standards Coordinator
carolina.thomasson@state.co.us

Colorado Department of Public Safety
Division of Criminal Justice
DVOMB
700 Kipling Street, Suite 3000, Denver, CO 80215
http://dcj.dvomb.state.co.us/
303-239-4528 or 303-239-4536

COLORADO
Department of Public Safety

Who Should Complete this Application?

All DVOMB approved providers newly approved on or prior to December 31, 2018, including those who are not practicing, who are RENEWING their listing with the DVOMB in order to continue providing services to court ordered domestic violence offenders. Approved Providers renew as individuals, not as partnerships or programs.

How to Complete this Application?

Please read all of the application in its entirety. It is updated and changed every renewal period.

- Please read all of the application in its entirety. It is updated and changed at each renewal period.

- The applicant should request assistance from a clinical supervisor in completing this application, if applicable.

- Within the body of this application, you will be asked to attest to your compliance with training and clinical experience according to very specific sections of the Standards. The applicant should first read and understand the Standards before completing this application. Within the body of this application, you will be asked to document your training; you may wish to compile these materials in advance.

- When complete, you should return a single-sided hard copy of the application with supplemental information to the address on the cover page, "Attention: DVOMB". You may choose to submit your application electronically to carolina.thomasson@state.co.us, if you choose to submit electronically, you must submit your payment via mail. Your application will be processed once payment is received. Save a copy of the completed application, including attached documents for your files.

- Additional copies of the Standards or the application materials may be obtained by contacting (303) 239-4536. Standards are also available at http://cdpsdocs.state.co.us/dvomb/Standards/standards18.pdf

- Questions may be addressed to the Standards Coordinator at (303) 239-4536 for questions pertaining to this application.

- Standards compliance will be assessed over time through a periodic renewal process (every two years), a monitoring process, and a mechanism to receive and investigate complaints within the policies established for such complaints and via Standards Compliance Reviews according to the DVOMB policy and procedure.

General Instructions

Your adherence to the instructions throughout the application will help ensure that your application is not returned to you by the Domestic Violence Offender Management Board staff or otherwise delayed.

1. Follow all instructions carefully.

2. Use the forms provided in this application.

3. Submit ONLY information requested, in the order requested.

4. Keep a copy of your completed application and attachments for your files.

5. All providers seeking to renew their DVOMB approval must submit a **$200 Money Order** or **Certified Check** payable to the "Colorado Department of Public Safety." No cash or personal checks will be accepted. Please submit your application electronically by email to carolina.thomasson@state.co.us and mail the Money Order or Certified Check separately to the address listed on the cover page of this application. **PLEASE WRITE YOUR NAME ON THE CHECK OR MONEY ORDER. If you do not write your name on the check or money order, the DVOMB cannot guarantee that your payment will process successfully.**

   a. **If you are a new provider approved on or after August 1, 2018, you are exempt from this fee, however must submit this completed form.** The fee is **NON-REFUNDABLE.**

   b. **If you are a new provider approved on or after January 1, 2019, you do not need to submit a renewal packet for the 2019 renewal period.**

6. Please complete and submit the enclosed "Contact Information Update Form." You may list up to a maximum of four addresses for listing. If you are "Not Currently Practicing" you are exempt from completing pages 11 and 12, yet you must provide updated contact information for mailing purposes.

APPLICANT NAME: _____

DATE: _____ DATE OF BIRTH: _____

For Continued placement on the Domestic Violence Offender Management Board Approved Provider List.

Please answer the following questions:

1. Are your practices in compliance with the *Standards for Treatment with Court Ordered Domestic Violence Offenders* (*Standards*)?
   ☐ YES ☐ YES, AND I HAVE A VARIENCE FOR SECTION _____ ☐ NO

   If no, you must attach a written explanation that includes why you are not in compliance with the *Standards.*

2. Since your last renewal have you been disciplined and/or found to engage in unethical behavior by any licensing or certifying body or professional organization? If yes, please attach an explanation.
   ☐ YES ☐ NO

3. Since your last renewal have you had a license or certification revoked, suspended, renewal refused, or been placed on probationary status by any professional licensing body? (This includes any currently pending challenge to your licensure, certification or registration.) If yes, please attach an explanation.
   ☐ YES ☐ NO

4. Since your last renewal have you voluntarily relinquished a license or certification to provide psychotherapy, or voluntarily or involuntarily terminated any mental health staff privileges? If yes, please attach an explanation.
   ☐ YES ☐ NO

5. Since your last renewal have you been arrested, charged, convicted, received a deferred judgment for, or pled nolo contender for any criminal offense? If yes, please attach an explanation.
   ☐ YES ☐ NO

6. In the past 2 years, have you been part of a civil or criminal protection order, as the protected party or the respondent. If yes, please attach an explanation.
   ☐ YES ☐ NO

Continuing Education

Please complete the chart below by filling in the continuing education hours (CEU's) you accrued between August 1, 2017 and July 31, 2019.

YOU ARE EXEMPTED FROM CEU'S IF YOU ARE A NEW PROVIDER APPROVED ON OR AFTER AUGUST 1, 2018.

If this applies to you, please initial here:_____

SPONSORING AGENCY	TITLE OF COURSE, PROGRAM, ETC.	DATE	HOURS EARNED
		TOTAL HOURS :	

PLEASE DO NOT SUBMIT COPIES OF YOUR CERTIFICATES AT THIS TIME. IN THE EVENT OF A STANDARDS COMPLIANCE REVIEW OR COMPLAINT, YOU WILL BE REQUESTED TO SUBMIT CERTIFICATES.

Policy Update Attestation

Please initial each policy update below. By initialing below, you attest that as of the date this renewal application, you have read, understand and implemented the following policy updates:

_____ **Appendix D - New Administrative Standards (Standards section 11.0)**
http://cdpsdocs.state.co.us/dvomb/Standards/D.pdf

_____ **Strangulation Memorandum Regarding the DVRNA Scoring**
http://cdpsdocs.state.co.us/dvomb/WhatsNew/Strangulation.pdf

_____ **Appendix C – Glossary of Terms**
http://cdpsdocs.state.co.us/dvomb/Standards/C.pdf

_____ **Standard 5.02 – Discussion Point**
https://cdpsdocs.state.co.us/dvomb/WhatsNew/502.pdf

_____ **Standards Section 9.0**
http://cdpsdocs.state.co.us/dvomb/WhatsNew/9.0REVISIONS.pdf

_____ **Release of Information Requirement for Research Purposes**
http://cdpsdocs.state.co.us/dvomb/WhatsNew/Release.pdf

_____ I understand it is my responsibility to stay up to date with DVOMB revisions and changes to policy which are made available via email, DVOMB communications such as the Quarterly Minute, and the website. If I am not receiving regular correspondence from the DVOMB, I understand it is my responsibility to contact Staff in order to problem solve any communication issues.

_____

DVOMB Approved Treatment Provider's Signature

Current Status Attestation

Please initial your current approval status:

_____ **Provisional Level -** By signing below, I verify that I have completed my 14 hours of continuing education as per the *Standards, Section 9.0.* I confirm that all the information contained in this Renewal Form is true. (Of the 14 hours, at least 7 shall be on victim issues and the balance on training requirements for Full Operating Level approval). I hereby attest I will maintain compliance with the *Standards* throughout this next renewal cycle. If I find difficulty maintaining compliance, I will refer to the Variance Process (*Standards, Section 11.16*), and seek guidance from DVOMB Staff.

Also approved for: ☐ Female Offender; ☐ LGBT+ Offender

_____ **Entry Level -** By signing below, I verify that I have completed my 14 hours of continuing education as per the *Standards, Section 9.0.* I confirm that all the information contained in this Renewal Form is true. (Of the 14 hours, at least 7 shall be on victim issues and the balance on training requirements for Full Operating Level approval). I hereby attest I will maintain compliance with the *Standards* throughout this next renewal cycle. If I find difficulty maintaining compliance, I will refer to the Variance Process (*Standards, Section 11.16*), and seek guidance from DVOMB Staff.

Also approved for: ☐ Female Offender; ☐ LGBT+ Offender

_____ **Full Operating Level -** By signing below, I verify that I have completed my 28 hours of continuing education as per the *Standards, Section 9.0.* I confirm that all the information contained in this Renewal Form is true. (28 hours every 2 years in topic areas relevant to improved treatment with court ordered domestic violence offenders. Of the 28 hours, diversity and victim issues shall be included). I hereby attest I will maintain compliance with the *Standards* throughout this next renewal cycle. If I find difficulty maintaining compliance, I will refer to the Variance Process (*Standards, Section 11.16*), and seek guidance from DVOMB Staff.

Also approved for: ☐ Female Offender; ☐ LGBT+ Offender

_____ **DV Clinical Supervisor Level –** By signing below, I verify that I have completed my 28 hours of continuing education as per the *Standards, Section 9.0.* I confirm that all the information contained in this Renewal Form is true. (28 hours every 2 years in topic areas relevant to improved treatment with court ordered domestic violence offenders. Of the 28 hours, diversity and victim issues shall be included). I hereby attest I will maintain compliance with the *Standards* throughout this next renewal cycle. If I find difficulty maintaining compliance, I will refer to the Variance Process (*Standards, Section 11.16*), and seek guidance from DVOMB Staff.

Also approved for: ☐ Female Offender; ☐ LGBT+ Offender

DVOMB Approved Treatment Provider's Signature

Pre-Sentence Evaluator Status

The revisions to Section 9.0 introduced a new Pre-Sentence Evaluator Status as an additional designation to be added to the DVOMB Approved Provider List, effective January 1, 2020. This status is not required for those who only wish to conduct post-sentence evaluations and does not prevent Approved Providers from completing post-sentence evaluations.

If you are a licensed mental health professional, you currently meet the requirements of the Standards and are eligible to request this additional status be added to your approval. If you would like to be considered for this process, please indicate YES and provide a letter to the Application Review Committee demonstrating how you meet the new criteria in Section 9.06.

Please note, all eligible DVOMB Approved Providers who decline this opportunity to be grandfathered into this status as part of the 2019 Renewal Period will have to apply and be approved under the new pre-sentence evaluator status application requirements.

☐ YES – I would like to be considered for the Pre-Sentence Evaluator Status

☐ NO – I am not interested in this Status at this time.

☐ NOT APPLICABLE – I am not a licensed mental health professional

Additional Services and Specific Populations

DVOMB staff are sometimes contacted by stakeholders looking for Approved Providers who have specialized services and are able to serve specific populations. Please indicate which of the following additional services you are capable of providing in addition to your status as an Approved Provider. Offering this information is completely voluntary and not required as part of the renewal application.

Specific Populations:

☐ Juvenile Offenders ☐ Young Adult Offenders ☐ Geriatric Population Offenders

☐ Developmentally or Intellectually Disabled Offenders ☐ Military Offenders

☐ Voluntary Clients (Individuals Not Subject to a Court Ordered)

Additional Services:

☐ Mental Health ☐ Substance Abuse ☐ EMDR ☐ DBT ☐ Anger Management

☐ Caring Dads ☐ Other Parenting Classes, Please specify: _____________

☐ Acudetox ☐ PCL-R/Psychopathy Evaluation ☐ Full Psychological Evaluation

☐ Languages Other than English: _______________

CONTACT INFORMATION UPDATE

The information below is requested for the purpose of updating the *DVOMB APPROVED PROVIDER LIST.* Providers may be listed up to a maximum of **four** times. If your contact information is not correctly listed, referral sources may not be able to contact you.

Please review your information on the DVOMB website: https://www.colorado.gov/pacific/dcj/find-treatment-provider-domestic-violence-offenders

IF NO UPDATES ARE REQUIRED, PLEASE DO NOT FILL OUT THIS SECTION BELOW AND CHECK THIS BOX: ☐

If information needs modifications, please fill out the section below.

Provider Name: ____

What are your DORA credentials (*CAC III, LPC, etc.*)?____________________________

Cell phone: ____

E-mail: ____

Please list languages (other than English) in which you provide DV treatment. _________

Please list for 1. AGENCY (below) your **PRIMARY** mailing address.

1. AGENCY NAME:

Address: ____

City: ___________________ County: _________________ Zip Code: ______________

Phone Number: _________________________ Fax Number: _______________________

☐ The mailing address I have listed above is my ***home*** address and should not be posted on the Approved Provider List.

- -

Please list up to three ***other*** offices where you provide domestic violence offender services.

2. AGENCY NAME:

Address: _____

City: _____ County: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

- -

3. AGENCY NAME:

Address: _____

City: _____ County: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

- -

4. AGENCY NAME:

Address: _____

City: _____ County: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Thank you for the valuable work you do!

Treatment Victim Advocate Information

☐ **Not Applicable – I am Not Currently Practicing.**

Your DV Treatment Victim Advocate must complete pages 7 and 8. If you use more than one TVA, please have EACH TVA complete this section separately and sign.

Name: _____

Address: _____

Email: _____ **Phone:** _____

Current Level: ☐ **Entry** ☐ **Fully Qualified**

Please answer the following questions.

To the best of your knowledge, is the DVOMB Approved Provider whom you provide Treatment Victim Advocate services to, in compliance with section 7.0 of the *Standards for Treatment with Court Ordered Domestic Violence Offenders* (*Standards*)?

☐ YES ☐ NO

Are you involved in the MTT decision-making for the treatment and supervision of DV offenders?

☐ YES ☐ NO

IF YOU RESPONED WITH NO TO ANY OF THE QUESTIONS ABOVE, YOU MUST ATTACH A WRITTEN EXPLANATION.

Mode of contact with MTT: ☐ In person ☐ Telephone ☐ Email ☐ Video chat (HIPAA compliant video chat, etc).

Do you work in any other roles at the agency or practice where you work as a TVA?

☐ YES ☐ NO

If yes, please explain: _____

What other volunteer or paid work you do outside of the agency or practice?

Treatment Victim Advocate Signature

_____

Domestic Violence Clinical Supervisor or Peer Consultant

☐ **Not Applicable – I am Not Currently Practicing.**

Your Domestic Violence Clinical Supervisor or Peer Consultant must complete the following page and sign. If you have more than one peer consultant, please add additional pages.

☐ **DV CLINICAL SUPERVISOR** ☐ **PEER CONSULTANT**

Satisfies: ☐ **MALE** ☐ **FEMALE** ☐ **LGBT+**

Name: _____

Address:_____

_____

Email:_____

Phone(s):_____

Mode of contact: ☐ **In person;**
Electronic modes of contact: ☐ **Telephone;** ☐ **Email;** ☐ **Video chat**

If electronic modes of supervision or peer consultation are utilized, has face-to face supervision or consultation occurred on no less than on a quarterly basis?

☒ YES ☐ NO; If no, please explain

Signature of Supervisor or Peer Consultant: _____