

REAPPLICATION 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)
Fax: (303) 239-4491
<http://dcj.state.co.us/odvsom/dvm.htm>

(Revised July 7, 2006)

COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD
REAPPLICATION PACKET

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COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD
REAPPLICATION PACKET

Reapplication and Information for Continued 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) 239-4491

<http://dcj.state.co.us/odvsom/dvm.htm>

Who should fill out this reapplication?

Previously approved providers requesting re-approval

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

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 reapplications may be returned.
5. The reapplication review process of the Committee will take a **minimum of three months**.
6. **Please do not** use staples, paper clips, binders, sheet protectors or other materials because all reapplications are copied multiple times in their entirety during processing.
7. **If there is a CBI fingerprint card enclosed**, a **money order** for \$39.50 made payable to “CBI” must be included for the processing of your fingerprint card.
8. A money order for \$100.00 made payable to “Colorado Department of Public Safety” must be included for investigator’s fee.
9. It is the reapplicant’s responsibility to obtain and review the current publication of the *Standards* since the *Standards* are revised periodically.
10. Reapplicants will be notified in writing that our office has received their reapplication packet and again in writing once the packet has been reviewed.
11. The ARC will review your documentation and make the determination regarding replacement on the Approved Provider List.
12. Make a copy of your reapplication for your records. Not all of the information in your reapplication will be archived by our office. Do not send the original training certificates.

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

Requirements for Reapplication Process

All current Approved Providers (including those originally listed on the 2001 Approved Provider List) must apply for continued placement on the Approved Provider List. Formerly approved providers who are requesting re- placement on the Approved Provider List must also complete all of the following requirements. Required documentation is listed below. The forms noted are included in this packet.

- Fingerprint Card (instructions on pages 31 & 32)
- Reapplication Fee (see page 6)
- Statement of Understanding Form (page 5)
- DORA Verification Form (page 7)
- Background and Identifying Information Form (page 8)
- Certification and Licensure Form (page 9)
- Criminal Background Information Form (page 10)
- Statement of Compliance Forms: (page 11)
 - Report of Any Practice that Conflicts or Varies from the *Standards*
 - Research Statement of Compliance
- Approved Domestic Violence Treatment Provider Adherence to All Provider Qualifications Affidavit (page 13)
 - Instructions for Completing Affidavit for Provider Qualification Form (page 12)
- Contact Information for Your References Form (page 14)
- Letter of Reference Forms:
 - Clinical Supervisor (page 15)
 - Victim Advocate (page 21)
 - Peer (page 19)
- Verification of Ongoing Clinical Supervision Form (page 27)
- Community Letters of Support Instructions (page 28)
- Any other documentation required by the Application Review Committee, as specified in your cover letter.

Frequently Asked Questions (FAQ)

Why is this procedure called a reapplication and not a renewal like the process from the Department of Regulatory Agencies?

- The reapplication process can be distinguished from a renewal in several ways. The reapplication involves a review of your practice, program, and clinical skills. In addition, letters of community support and reference letters are also required. Your documentation will be reviewed to determine whether your continued placement will be granted or denied. A renewal generally does not require any of these types of documentation.

I just went through a very thorough process for my 2001 documentation. Why do I have to once again submit additional documentation?

- The 2001 documentation was required by statute to obtain basic initial information and proof of compliance with the then existing standards on Approved Providers. This is the reapplication process that will be required every three years. The purpose of this process is to verify current compliance with the *Standards*.

Will all Providers be re-applying at the same time?

- Providers will not all be re-applying at the same time. Approximately thirty names will be selected randomly each quarter for the next three years. The reapplication process is being staggered so the Board can respond expeditiously.

How often will Providers have to re-apply?

- You will have to re-apply every three years. Your anniversary date for re-applying will be three years from the date your first reapplication is due. You will be notified, once your reapplication packet is accepted by the Board, of your subsequent reapplication period.

What should a Provider do upon completion of this reapplication?

- When completed, send reapplication 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 reapplication for your records.) **PLEASE DO NOT FAX IN ADDITION TO MAILING HARD COPIES, DUPLICATIONS ARE UNNECESSARY.**

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

- Please expect the reapplication review process to take a **minimum of three months**. You can expedite the process by submitting all of your reapplication materials at one time and in the required order. (Note: if your packet is incorrect or incomplete, this slows down the approval process).
- **Do not send information that is not requested. Excessive documentation will result in your packet being returned to you.**

What are my additional responsibilities as an Approved Treatment Provider?

- 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, of any changes in your professional status, such as: 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.

Will there be onsite monitoring or auditing?

- According to the *Standards* Section 9.15, while not routinely performed, the Board may audit for provider compliance when necessary.

Statement of Understanding Form

What Will Be Done With Information I Provide on the Reapplication?

I understand that the information I have submitted for this reapplication 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 reapplication 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 reapplication, 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 Provider: _____ Date _____

Name of Provider (type or print legibly): _____

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Reapplication Fee

Reapplicant Name _____

Reapplicant Phone Number _____

Please attach the following:

A money order for \$100.00 is required to cover the cost of your investigation. Please make the money order payable to Colorado Department of Public Safety (please do not use acronym). *Please note that 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 the applicant not to exceed one hundred twenty-five dollars per application to cover the costs of conducting the current background investigation required by this subsection (2).

Department of Regulatory Agencies (DORA) Verification Form

To be completed by the Approved Domestic Violence Treatment Provider

PLEASE INCLUDE THIS PAGE IN YOUR REAPPLICATION 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 or registration, complaints, letters of concern and any disciplinary actions to the Domestic Violence Offender Management Board.

Signature

Date

Background and Identifying Information Form

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

Provider Name: _____
(You must apply as an individual, not as a program or partnership.)

Maiden Name/other names used: _____

Gender: Male Female
(Required for criminal background check)

Social Security Number: _____
(Required by federal law)

Date of Birth: _____

Business Name: _____

*****Requested information below is public record. For safety reasons, do not use your private residence.
***If any of the following information has changed, please check box [____].**

Primary Business Address: _____

Telephone: _____ Fax: _____ E-mail: _____

Do you have multiple business addresses or phone numbers: No Yes (If yes, please list below.)

1. _____

2. _____

3. _____

County(ies) of Business Address(es): 1. _____ 2. _____ 3. _____

Judicial districts where you provide services: 1. _____ 2. _____ 3. _____

List languages (other than English) in which you are fluent and can provide treatment (this will be placed on the Provider List):

Please check the specialty areas in which you provide treatment for domestic violence offenders
 Female offenders Gay or Lesbian offenders

Certification and Licensure Form

1. Do you have a current Colorado license or certification from the Department of Regulatory Agencies to practice psychotherapy? YES NO

If yes, please indicate type:

- | | |
|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Psychiatric Clinical Nurse Specialist |
| <input type="checkbox"/> Social Worker Level <input type="checkbox"/> LCSW <input type="checkbox"/> LSW (Please check) | <input type="checkbox"/> Licensed Marriage and Family Therapist |
| <input type="checkbox"/> Alcohol & Drug Abuse Counselor (please specify level) _____ | <input type="checkbox"/> Licensed Professional Counselor |
| <input type="checkbox"/> Licensed Addiction Counselor | <input type="checkbox"/> Licensed Psychologist |
| <input type="checkbox"/> Other (Please specify) _____ | |

2. If you are not licensed or certified, you must be registered with the Unlicensed Database. Are you registered? YES NO

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

4. Have you ever been licensed or certified to practice psychotherapy in any other states? YES NO
If yes, please list those states. _____

5. Have you ever been found to engage in unethical behavior by any professional organization?
 YES NO If yes, please explain: _____

6. 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: _____

7. 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: _____

8. Have you ever voluntarily or involuntarily limited, reduced or lost any clinical privileges? YES NO
If yes, please explain: _____

9. Do you have any pending professional liability or malpractice actions, final judgments or settlements involving your professional practice? YES NO If yes, please explain: _____

Criminal Background Information Form

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

If yes, please explain: _____

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

If yes, please explain: _____

3. Have you ever been convicted of a felony? YES NO

If yes, please explain: _____

4. Have you ever been convicted of a misdemeanor? YES NO

If yes, please explain: _____

Statements of Compliance Forms

Report of Any Practice that Conflicts or Varies from the *Standards* (9.10d)

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*.

There are aspects of my practice that are not in complete compliance with the Standards. YES NO
If you answered yes please explain below:

If you need technical assistance with your practice on this issue, contact Cheryl Davis at 303-239-4456.

Signature of Applicant: _____

Date _____

Applicant Name (type or print legibly): _____

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) _____

Instructions for Completing Affidavit for Provider Qualification Form

The following affidavit stating that the Approved Treatment Provider has met all the **provider qualifications** has significant legal consequences and must be completely and accurately filled out in order to process your application.

The Board is statutorily mandated to verify that all providers on the Approved Provider List, who were formerly certified by their local board, meet the qualifications of the *Standards*. Therefore the Board determined that the most efficient way to verify adherence to the provider qualifications was to have providers complete an affidavit verifying the trainings. **Therefore do not send certificates that correspond to the trainings listed on the following page with this reapplication.**

Please complete the following steps in filling out the affidavit form on the following page:

1. At the top of the form, fill in the name of the county where you practice and print your name on the first line.
2. Please read each line carefully, and in your own handwriting, **place your initials in the space provided** to the left of each numbered line. By initialing each line on the **provider qualifications affidavit**, you are certifying that the information on that line can be verified as true and correct.
3. Have your signature notarized.

Contact Information for Your References Form

Please list below names, addresses, and phone numbers of the following three (3) references:
(These must be three *different* individuals.)

1. a. Your clinical domestic violence supervisor if you are unlicensed (“Clinical Review for Unlicensed Providers”)

or

b. Your peer consultant if you are licensed (“Peer Consultant Resource Form”)
2. The advocate who provides victim advocacy for your program; and,
3. An Approved Domestic Violence Treatment Provider.

You are responsible for sending each of these individuals the *appropriate, corresponding* copy of the form from the following pages entitled, “Letter of Reference.” Each reference must include their place of employment, address, and phone number on their letter and they must submit it DIRECTLY to: Domestic Violence Offender Management Board c/o Division of Criminal Justice, 700 Kipling Street, Suite 1000, Denver, CO 80215.

1. (a or b) Name: _____

Position: _____

Address: _____

Telephone number(s): _____

2. Name: _____

Position: _____

Address: _____

Telephone number(s): _____

2. Name: _____

Position: _____

Address: _____

Telephone number(s): _____

Clinical Review for Unlicensed Providers Submitted by Domestic Violence Clinical Supervisor

The **Unlicensed** Approved Domestic Violence Treatment Provider (Provider) is required to fill in the top portion of this form and then give it to his/her approved domestic violence clinical supervisor. The reference must then mail it **directly** to the address at the bottom of this form found on page 17 (not to the Approved Treatment Provider).

Name of Provider (please print or type)

Signature of Provider

Date

Telephone Number

(your signature waives your right to review this letter of reference)

TO BE FILLED IN BY CLINICAL SUPERVISOR:

I understand that (Provider's name) _____
has re-applied for Continued Placement on the Colorado Domestic Violence Offender Management Board
Approved Provider List as an Approved Treatment Provider. The Provider has requested that I provide a
statement regarding his/her professional and ethical qualifications. I certify that the answers and statements
provided below are true and complete to the best of my knowledge.

The Board would appreciate your honest response. Please send this form directly to our office. The Provider will not be given a copy of your response. If Provider deficiencies are identified, they will be addressed confidentially, without revealing the source.

THIS FORM MUST BE USED. PLEASE ANSWER ALL QUESTIONS. ADDITIONAL PAGES MAY BE ADDED.

Please print or type the following information

1. Supervisor's Name: _____

2. Occupation: _____

3. Place of employment: _____

Address: _____ Phone #: _____

4. How many years have you known the Provider professionally? _____ Personally? _____

5. How long have you worked with this Treatment Provider? (specify time) _____

Have you known him/her in any other context? If so, what? Please explain. _____

6. Average size of the supervisee's domestic violence treatment caseload? _____

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7. How often do you meet with this Provider for supervision? _____
8. We meet: in person by phone other (specify) _____ (Check all that apply.)
9. How many cases do you normally review at each meeting? _____
10. Do you review actual intake evaluation packets and summaries performed by the Provider? _____

Supervisors: based upon supervision, please comment on any areas of Provider strengths or weaknesses when answering the following questions:

11. Please comment on the evaluations performed by the Provider including the content as it relates to the *Standards*, (Section 4.01, 4.02, 4.03)
12. Please comment on the degree to which the Provider effectively addresses and responds to offender substance abuse issues in evaluations and in treatment. [Section 5.10(a) & (b)]
13. Please comment on the Provider's ability to effectively address offender manipulation and offender accountability.
14. Please comment on the Provider's consultation and collaboration with referring criminal justice agencies.
15. Please comment on the Provider's consultation and collaboration with other DV treatment providers on issues such as: transferred cases, pre-sentence evaluations.

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16. Does the Provider have a victim advocate?

YES NO (If no, please explain.)

17. Please comment on the Providers adherence to the *Standards* regarding consultation with the victim advocate (absences, reducing the length of treatment, couple's meetings, etc.)

18. Do you think he/she comprehends and is attentive to victim issues? YES NO

Also please comment on the Provider's work as it relates to victim advocacy and safety. Please provide examples of areas of strengths and/or weaknesses.

19. Are you aware of any treatment approaches or practices the Provider uses that blames or intimidates the victim? YES NO

If yes, please comment on what is done to address this and how the Provider responds.

20. Overall, what are the Provider's strengths and weaknesses regarding his/her work with domestic violence offenders?

21. Do you believe the Provider demonstrates integrity in professional and personal behavior?

YES NO (If no, please explain.)

22. To the best of your knowledge, has the Provider ever been investigated and/or involved in unprofessional, illegal, or unethical conduct? YES NO (If yes, please explain.)

23. Are you aware of any practices that this Provider engages in that are in conflict with the *Standards*?

YES NO (If yes, please explain.)

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24. How would you recommend this Provider for continued placement on the Approved Provider List?
- | | |
|-------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> highly recommend | <input type="checkbox"/> have reservations about recommending |
| <input type="checkbox"/> recommend | <input type="checkbox"/> do not recommend |

(Please explain your response below.)

25. What content is covered during supervision? Please check all that apply.

Standard 9.21

- a. Discussion of case coordination with victim, victim advocate, and/or victim's therapist
 - b. Discussion of services provided by the supervisee
 - c. Discussion of treatment plans, intervention strategies, and evaluations of offender's progress for each offender seen by the supervisor
 - d. Administrative procedures of the practice as they relate to clinical issues
 - e. Discussion of ethical issues
 - f. Evaluation of supervisory process including performance of the supervisor and supervisee
 - g. Coordination of services among other professionals involved in particular cases, such as probation, criminal justice, and victim service agencies
 - h. Colorado *Standards for Treatment with Court Ordered Domestic Violence Offenders*
 - i. Relevant Colorado laws, rules and regulations, including confidentiality and duty to warn
 - j. Discussion of offender resistance, transference, and counter-transference issues
- Other (please specify) _____

26. If you have any additional comments regarding the Provider please note them below.

Reference's Signature: _____ Date: _____ Telephone Number: _____

***Reference: you must send this form directly to: Domestic Violence Offender Management Board, Division of Criminal Justice, 700 Kipling Street, Suite 1000, Denver, CO 80215. Do not return this to the Provider.**

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PEER CONSULTANT RESOURCE FORM

Peer Consultants' Name: _____

Name of Provider with whom you do peer consultation: _____

Please list your license (s) with the Department of Regulatory Agencies: _____

This form is meant to be used as a guide in writing your letter of reference for the Provider with whom you do peer consultation. The primary goals of the *Standards for Treatment with Court Ordered Domestic Violence Offenders* are victim safety and cessation of violence. Peer consultation is a vital part of domestic violence offender containment and treatment. Because this is a potentially dangerous population that tends to manipulate, consistent communication with other providers and a peer consultant is a critical aspect of effective treatment. Therefore, a required component of the reapplication process for all licensed, approved providers is input from the peer consultant. We would appreciate your honest response.

To the best of your ability, please address the following issues in your letter of reference. The *Standards* are noted for your reference.

1. The Provider's use of a victim advocate (7.02)
2. The provider's comprehension and attention to victim issues (7.04, 7.05, 7.06)
3. Based on your consultation with this Provider, address his/her assessment, screening, and/or intervention with substance abuse issues in evaluation and treatment of offenders according to the *Standards* [4.01(c)(5), 5.10]
4. Consistent use of intake evaluations per the Standards (4.02)
5. The Provider's use of clinical skills in addressing offender manipulation and offender accountability.
6. The Provider's collaboration and consultation with their referral sources i.e. responsible criminal justice agency (8.0)
7. Consultation with previous treatment providers on transferred cases (6.04)
8. If any treatment approaches or practices that the provider uses that blames or intimidates the victim, please address this in your letter. (5.02)

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**ADDITIONAL RESOURCES
FOR PEER CONSULTANT'S LETTER OF REFERENCE**

The following is provided as a reference for you regarding content that should be covered during consultation. These are areas that you may choose to address in your letter of reference. The standard is noted for your reference.

Standard 9.21:

- (a) Discussion of case coordination with victim, victim advocate, and/or victim's therapist
- (b) Discussion of services provided by the supervisee
- (c) Discussion of treatment plans, intervention strategies, and evaluations of offender's progress for each offender seen by the supervisee
- (d) Administrative procedures of the practice as they relate to clinical issues
- (e) Discussion of ethical issues
- (f) Evaluation of supervisory process, including performance of the supervisor and supervisee
- (g) Coordination of services among other professionals involved in particular cases, such as probation, criminal justice and victim service agencies
- (h) Colorado Standards for Treatment with Court Ordered Domestic Violence Offenders
- (i) Relevant Colorado laws, rules and regulations, including confidentiality and duty to warn
- (j) Discussion of offender resistance, transference, and counter-transference issues

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Letter of Reference from Provider's Victim Advocate Form

The Approved Domestic Violence Treatment Provider (Provider) is required to fill in the top portion of this form and then give it to his/her victim advocate to complete. The reference must then mail it **directly** to the address at the bottom of this form (not to the Approved Treatment Provider).

Name of Provider (please print or type)

Signature of Provider

Date

Telephone Number

(your signature waives your right to review this letter of reference)

ADVOCATE COMPLETES THIS SECTION

I understand that (Provider's name) _____
has re-applied for continued placement on the Colorado Domestic Violence Offender Management Board
Approved Provider List as an Approved Treatment Provider.

The Provider has requested that I provide a statement regarding his/her professional and ethical qualifications. I certify that the answers and statements provided below are true and complete to the best of my knowledge. **This form must be used. Additional pages may be added.**

Communication between the Provider and the victim advocate is a vital part of victim safety and domestic violence offender containment. Therefore, a required component of all Approved Provider's Reapplication process is input from the victim advocate. The Board would appreciate your honest response. Please send this form directly to our office. The Provider will not be given a copy of your response. If Provider deficiencies are identified they will be addressed confidentially, without revealing the source.

Please print or type the following information

1. Victim Advocate's Name: _____

2. Occupation: _____

3. Place of employment: _____

Job Title: _____

Address: _____ Phone #s: _____

4. How many years have you known the Provider professionally? _____ Personally? _____

5. How long have you worked with this treatment provider? (specify time) _____

Have you known them him/her in any other context? YES NO If yes, please explain.

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6. Choose **all** that apply:

- I am employed at the Provider's agency. I am contracted individually by the Provider.
 I am a treatment provider. I am contracted through a local DV agency.

7. On average, how many victims are normally on your caseload for this Provider?

- 0-10 11-20 21-30 31-40 over 40

8. On average, how many domestic violence offenders does the Provider normally have on their caseload?

- 0-10 11-20 21-30 31-40 over 40
-

INSTRUCTIONS

The primary goals of the *Standards for Treatment with Court Ordered Domestic Violence Offenders* are victim safety and cessation of violence. Certain standards require notification, consultation, or communication between provider and victim advocate. With that in mind, please answer the following questions regarding your relationship with the Provider. Each corresponding standard has been identified for your convenience. Please familiarize yourself with each standard and the Guiding Principles (3.0) prior to selecting your response. Answer to the best of your knowledge.

Regarding the following standards, please provide input regarding the Provider's interaction with you. To the best of your knowledge please respond to the question based on the previous six months. Where numbers are requested estimates are acceptable:

9. What is the process of communication between the Provider and yourself for how you review cases? Do you meet: (choose all that apply)

- weekly: monthly in person by phone on a regular basis as certain issues arise

Other (please specify) _____

10. Is this effective in strengthening communication between the Provider and yourself as well as promoting victim safety? Please describe: _____

11. Couple's Meetings (5.11)

Frequency of Treatment Provider consultation and coordination with you regarding couple's meetings?

- Consistently Occasionally Seldom I am unaware of any couple's meetings

Other / comment _____

12. Couple's Therapy (5.12)

Treatment Provider's use of couple's therapy with DV offenders and their partner.

- None I do not know Yes If yes, please answer the following questions:

Number of cases where couple's therapy was used _____

If couple's therapy was used, were you present at each session?

- Yes No If no, why not? _____

Other / comment _____

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13. Reducing the Length of Treatment (5.08)

Has the Provider reduced the length of treatment for any offenders?

- Yes No I do not know

If your response was yes to Question 13, please answer the following question:

Did the Provider consult with you? Yes No

Comment: _____

14. Changes to Intensity of Treatment (5.09)

Has the Provider notified you of any changes in the intensity of treatment for any offenders?

- Yes No I do not know

If your response was yes to Question 14, please answer the following question:

Did the Provider consult with you? Yes No

Comment _____

15. Violations of contract (6.12)

How often does the Provider notify you of offenders that have violated their offender contracts?

- Consistently Occasionally Seldom

Did the Provider consult with you? Yes No

Comment _____

16. Absences (6.11)

How often does the Provider notify you of offender absences?

- Consistently Occasionally Seldom

Other / comment _____

17. Treatment Discharge (6.05-6.09)

How often does the Provider consult with you prior to offender treatment discharge?

- Consistently Occasionally Seldom

Other / comment _____

18. Release for contacting the victim (11.08)

How often does the Provider obtain releases for contacting victims?

- Consistently Occasionally Seldom

Other / comment _____

19. Victim safety issues (7.04)

How often does the Provider utilize interventions with the offender that promotes victim safety? (such as: allowing service of a protection order during group, responding to victim concerns with appropriate intervention, mental health evaluation, random UA)

- Consistently Occasionally Seldom

Other / comment _____

20. How often does the Provider consult with you on victim safety and offender containment issues?

- Consistently Occasionally Seldom

Other / comment _____

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21. Does the Provider engage in victim blaming? YES NO I am not aware of any victim blaming
Is the Provider receptive to mutual discussion on this topic?
 Consistently Occasionally Seldom

22. How would you recommend this Provider for continued placement on the Approved Provider List?
 highly recommend have reservations about recommending
 recommend do not recommend

(Please explain your response below.)

23. Are you aware of any practices that this Provider engages in that are in conflict with the *Standards*?
 YES NO (If yes, please explain.)

24. Is the Provider providing advocacy per the *Standards*?
 highly agree have reservations about agreeing
 agree do not agree

25. Any additional comments on the Provider's work as it relates to victim advocacy and safety may be added below:

Reference's Signature: _____ Date: _____ Telephone Number _____

***Reference: you must send this form directly to: Domestic Violence Offender Management Board, Division of Criminal Justice, 700 Kipling Street, Suite 1000, Denver, CO 80215. Do not return this to the Provider.**

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Letter of Reference from Approved Provider Form

The Approved Domestic Violence Treatment Provider (Provider) is required to fill in the top portion of this form and then give it to a peer Approved Provider to complete. The reference must then mail it **directly** to the address at the bottom of this form (not to the Approved Treatment Provider).

Name of Provider (please print or type)

Signature of Provider

Date

Telephone Number

(your signature waives your right to review this letter of reference)

I understand that (Provider's name) _____

has re-applied for continued placement on the Colorado Domestic Violence Offender Management Board Approved Provider List as an Approved Treatment Provider.

The Provider has requested that I provide a statement regarding his/her professional and ethical qualifications. I certify that the answers and statements provided below are true and complete to the best of my knowledge.
THIS FORM MUST BE USED, ADDITIONAL PAGES MAY BE ADDED.

Please print or type the following information

1. Name: _____

2. Occupation: _____

3. Place of employment: _____

Address: _____ Phone #s: _____

4. How many years have you known the Provider professionally? _____ Personally? _____

5. In what context are you familiar with the Provider's work as a domestic violence offender treatment provider?

6. Do you believe the Provider demonstrates integrity in professional and personal behavior?

YES NO (If no, please explain.)

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7. To the best of your knowledge, has the Provider ever been investigated and/or involved in unprofessional, illegal, or unethical conduct? YES NO (If yes, please explain.)

8. Please include below a list of the Provider's strengths and weaknesses regarding his/her work with domestic violence offenders.

9. How would you recommend this Provider for continued placement on the Approved Provider List?

- | | |
|-------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> highly recommend | <input type="checkbox"/> have reservations about recommending |
| <input type="checkbox"/> recommend | <input type="checkbox"/> do not recommend |

(Please explain your response below.)

10. Are you aware of any practices that this Provider engages in that are in conflict with the *Standards*?

- YES NO (If yes, please explain.)

11. Is the Provider providing advocacy per the *Standards*?

- | | |
|---------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> highly agree | <input type="checkbox"/> have reservations about agreeing |
| <input type="checkbox"/> agree | <input type="checkbox"/> do not agree |

Reference's Signature: _____ Date: _____ Telephone Number _____

***Reference: you must send this form directly to: Domestic Violence Offender Management Board, Division of Criminal Justice, 700 Kipling Street, Suite 1000, Denver, CO 80215. Do not return this to the Provider.**

Verification of Ongoing Clinical Supervision Form

Reference the *Standards*, Sections 9.18 & 9.19 *Ongoing Clinical Supervision Requirements* and Section 9.20 *Qualifications of Domestic Violence Clinical Supervisors*. **Unlicensed providers shall utilize the top half of this form. Licensed Providers shall utilize the lower half of this form.**

SUPERVISOR OF UNLICENSED PROVIDER

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

Clinical Supervisor as required by the *Standards* Section 9.20. I further verify that I am providing supervision for
_____ as required by the *Standards* Section 9.19
(Provider)

and that this supervision began on _____. This supervision consists of _____ hours
(date)

a month of group and _____ hours a 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

PEER CONSULTANT FOR LICENSED PROVIDER

I, _____ do hereby verify that I am a licensed and Approved Domestic Violence
(licensed peer provider)

Offender Treatment Provider. I further verify that I participate in peer consultation for a minimum of two
hours per month per the *Standards* Section 9.18 with _____.
(Licensed Provider)

(Signature of Licensed Approved Peer Provider)

Date

Verification of Ongoing Co-Facilitation Form

Court ordered domestic violence offender treatment can only be provided by an Approved Provider. Therefore, while an applicant is in training and/or during his/her application process, 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.

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 of this form.

I, _____ do hereby verify that I am co-facilitating all
(Approved Domestic Violence Treatment Provider) [as required by Section 9.05(d)]

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

(Applicant)

I further verify that I will continue to provide co-facilitation for this applicant during the entire 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 (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
(Applicant)

working in the 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

**Domestic Violence Offender Management Board
Division of Criminal Justice
700 Kipling St. Suite 1000
Denver, CO 80215**

Community Letter of Support

All Approved Providers must submit community letters of support from each of the following three entities:

1. Letter from a local community based domestic violence victim program. (i.e., a local domestic violence shelter, or victim resource program that is a non-governmental program. This is not a letter from your victim advocate.)
2. Letter from a primary referral resource (i.e., state probation, private probation).
3. Letter from the local domestic violence task force. (If Approved Provider is not participating in a local task force, then he/she must document why he/she is not participating. Please refer to *Standards*, Section 9.07g)

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 Approved Provider?
2. What is the context in which the agency or entity is familiar with the Approved Provider?
3. What is the type and level of the Approved Provider's involvement with the entity or agency?
4. What is the Approved Provider's involvement in the community? For example, does she/he tend to work in isolation, or as a collaborative team with other domestic violence containment components (such as probation, victim services, human services, etc.)?
5. What is your agency or entity's impression of the Approved Provider's behavioral management and containment of domestic violence offenders?
6. Are you aware of any practices of this Approved Provider that are in conflict with the *Standards*? If yes, please explain.

The Committee would appreciate your input regarding any concerns you may have regarding the provider. Additionally, any strengths of the provider that you wish to convey would be helpful as well. For items 4-6, please answer to the best of your knowledge. If you do not have any knowledge of the provider on those particular issues, please state that.

Guidelines for Obtaining Community Letters of Support from Local Victim Services Programs

These guidelines are intended to assist you in completing the requirement in the Reapplication for obtaining community letters of support from local victim services programs. Local victim services are defined by the Board as non-governmental, local victim services programming, such as a domestic violence shelter program.

Working with local victim service programs in your community is an important component of the *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Providers have a responsibility for developing a community approach to the provision of treatment and maintaining cooperative working relationships with domestic violence victim services.

The Domestic Violence Offender Management Board (Board) anticipates that the community letters of support will always be a component of the Reapplication process. If you are having difficulty obtaining a letter of support from a local community based victim services program, the Board has the following suggestions for fulfilling this requirement:

1. The preferred first choice is to attempt to obtain a letter from the local domestic violence shelter program in your community.
2. If you are unable to make contact with the domestic violence shelter program, please document in a brief statement for the Board why you were unable to obtain this letter of support. Please submit this to the Board. You may then attempt to obtain a letter from a different agency such as The Colorado Anti-Violence Program or Project Safeguard that provide non-governmental support to victims in your community.
3. If you are still unable to obtain any letters by the deadline, please submit a written statement to the Board explaining the attempts you have made to obtain these letters and why you were unsuccessful. You must also outline the steps you plan to take to create links and relationships with local victim community based programs. The Board anticipates that this will always be a component of the Reapplication process and encourages you to continue to build these important relationships.

Fingerprint Card Instructions

Colorado Revised Statutes (16-11.8-103 (4) (b) (III) (A) C.R.S.) require that applicants must submit one set of fingerprints for use by the Colorado Bureau of Investigation (CBI) and for transmittal to the Federal Bureau of Investigation (FBI). All current Approved Providers and all new applicants are required to submit a fingerprint card.

The form on the following page is a replica of the fingerprint card that is enclosed.

Please read the instructions below carefully:

1. You must use the fingerprint card that is enclosed. (Do not substitute it for a fingerprint card from your local law enforcement agency.)
2. Take the enclosed card to your local law enforcement agency for fingerprinting. (They will charge you a fee.)
3. Pay close attention to the numbered description of each category that needs to be filled out. Any inaccuracies will result in your card being returned to you which will delay the process and may result in additional fees.
4. Use black ink only.
5. All information written must be contained within each box. Do not write on any blue lines.
6. Do not highlight any information.
7. You must submit your completed fingerprint card (along with an enclosed money order or cashier's check made out to CBI for \$39.50) to:

Dana LaPointe
Domestic Violence Offender Management Board
Division of Criminal Justice
700 Kipling Street, Suite 1000
Denver, CO 80215

8. Insert information into boxes on fingerprint card according to the **sample** and list on the next page.

COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD
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Fingerprint Card Instructions (page 2)

SAMPLE:

APPLICANT	LEAVE BLANK	TYPE OR PRINT ALL INFORMATION IN BLACK						<u>FBI</u>	LEAVE BLANK
		LAST NAME <u>NAM</u> (1)	FIRST NAME	MIDDLE NAME					(21)
SIGNATURE OF PERSON FINGERPRINTED (12)		ALIASES <u>AKA</u> (2)	O R I	CO030085C ST DIV CRIM JUST DENVER, CO					DATE OF BIRTH <u>DOB</u> Month Day Year (10)
RESIDENCE OF PERSON FINGERPRINTED (13)									
DATE (14)	SIGNATURE OF OFFICIAL TAKING FINGERPRINTS	CITIZENSHIP <u>CTZ</u> (3)	<u>SEX</u> (4)	<u>RACE</u> (5)	<u>HGT</u> (6)	<u>WGT</u> (7)	<u>EYES</u> (8)	<u>HAIR</u> (9)	PLACE OF BIRTH <u>POB</u> (11)
EMPLOYEE AND ADDRESS (15)		YOUR NO. <u>OCA</u> (20)	LEAVE BLANK						
		FBI NO. <u>FBI</u>	CLASS _____						
REASON FINGERPRINTED (16)		ARMED FORCES NO. <u>MNU</u>	REF. _____						
		SOCIAL SECURITY NO. <u>SOC</u> (17)							
		MISCELLANEOUS NO. <u>MNU</u> (18)							
(19)									

PLEASE FILL OUT ENCLOSED FINGERPRINT CARD AS FOLLOWS:

- | | |
|--------------------|---------------------------------------------------------------------------------------------------|
| 1. NAME | Type or print Last, First and Middle Name |
| 2. AKA | Maiden name, other married names or any other name used |
| 3. CITIZENSHIP | U.S. (if born in the U.S) or Alien registration number |
| | 3A.AMOUNT DO NOT FILL IN |
| 4. SEX CODES | M (Male) F (Female) |
| 5. RACE CODES | W (White) B (Black) W (Hispanic) I (Indian) A (Asian – Oriental) |
| 6. HEIGHT | Feet and inches (for example 5'6" = 506; 6' = 600) |
| 7. WEIGHT | 090,100,250, etc. |
| 8. EYE CODES | BLK (Black), BLU (Blue), BRO (Brown), GRN (Green), GRY (Gray),
HAZ (Hazel), XXX (Unknown) |
| 9. HAIR CODES | BAL (Bald), BLK (Black), BRO (Brown), GRY (Gray), RED (Red/Auburn),
WHI (White), XXX (Unknown) |
| 10. DOB | Date of Birth |
| 11. POB | Place of Birth |
| 12. SIGNATURE | Signature of person fingerprinted – Individual's Signature |
| 13. RESIDENCE | Complete mailing address of person fingerprinted; includes city, state, & zip code |
| 14. DATE | Date Printed; Signature of <u>Law Enforcement Official</u> taking fingerprints |
| 15. EMPLOYER | DO NOT FILL IN |
| 16. REASON PRINTED | DO NOT FILL IN |
| 17. SOC | Social Security Number |
| 18. MISCELLANEOUS | DO NOT FILL IN |
| 19. FINGERPRINTS | All Applicants prints should be taken by a law enforcement agency |
| 20. OCA | DO NOT FILL IN |
| 21. FBI | DO NOT FILL IN |