

COLORADO SEX OFFENDER MANAGEMENT BOARD

**RE-APPLICATION FOR PLACEMENT
ON THE
PROVIDER LIST
AS A:**

**TREATMENT PROVIDER, EVALUATOR, and
POLYGRAPH EXAMINER, for
*ADULT SEX OFFENDERS AND JUVENILES
WHO HAVE COMMITTED SEXUAL
OFFENSES***



**Colorado Department of Public Safety
Division of Criminal Justice
Office of Domestic Violence and Sex Offender Management
Sex Offender Management Board
700 Kipling Street, Suite 3000, Denver, CO 80215
Email: somb@cdps.state.co.us
<http://dcj.state.co.us/odvsom/>
Telephone: (303) 239-4526 Fax:(303) 239-4491**

Who should complete this application?

Individuals who are currently listed and wish to continue providing services to convicted adult sex offenders and/or adjudicated juveniles who have committed a sexual offense (first reapplication). If this is your second or subsequent reapplication this is not the appropriate form.

Applicants must demonstrate that they have met and continue to meet the qualifications and have a history of compliance with standards of practice contained in *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* and the *Standards and Guidelines For The Evaluation, Assessment, Treatment, and Supervision of Juveniles Who Have Committed Sexual Offenses* published by the Sex Offender Management Board, (SOMB) and, if applicable, *the Standards for Community Entities That Provide Supervision and Treatment for Adult Sex Offenders who have Developmental Disabilities*. Applicants should apply as individuals, not partnerships or programs.

How to complete this application:

- Within the body of this application, you will be asked to document your training and experience; you may wish to compile these materials in advance.
- When complete, the application should be returned in hard copy to the address on the cover page, “Attention: SOMB”. Save a copy of the completed application and attached documentation for your files.
- Additional copies of the *Standards* or the application materials may be obtained by contacting (303) 239-4526. Standards are also available on the Internet at: http://dcj.state.co.us/odvsom/sex_offender. Standards were updated on 3/28/08.
- Questions may be addressed to Cathy Rodriguez at (303) 239-4499 for questions pertaining to the adult portion of this application and Kristy Alles-Serrant at (303) 239-4197 for questions pertaining to the juvenile portion of this application.

Additional Responsibilities if you are placed on the Provider List:

- To notify the SOMB, in writing of any changes in your name, address, telephone number, program name, program materials or if you have added an additional treatment location. This should be done as soon as possible to avoid administrative problems and accurate placement on the approved provider list.
- To provide the SOMB, in writing, information regarding any changes to your professional status, such as grievances, license revocations, criminal charges/arrest or any other change in your professional standing.

GENERAL INSTRUCTIONS

1. Use the forms provided in this application.
2. Submit ONLY the information requested.
3. Submit the required information **in the order requested.**
4. Follow all instructions carefully as incorrect applications WILL delay the process.
5. **KEEP A COPY OF YOUR COMPLETED APPLICATION AND ATTACHMENTS FOR YOUR FILES.**
6. Please remove pages i through ix before mailing in your completed application and any pages not applicable to your application status.
7. PLEASE DO NOT use staples, paper clips, binders, sheet protectors or other materials because all applications are copied multiple times in their entirety during processing.
8. Please submit all materials on SINGLE-SIDED COPIES .
9. ALL applicants MUST submit a **money order** for **\$100.00** made payable to **Colorado Department of Public Safety.** This is utilized to for the cost of your background check pursuant to C.R.S. and current Standards.

Which application pages should I fill out and submit?

- There is a grid on the next page to assist you in this process.
- If you are applying for multiple listings, please note that only ONE copy of each requested item is required.

Compliance with the Standards will be assessed over time through a periodic renewal process, a monitoring process, and a mechanism to receive and investigate complaints within the policies established for such complaints.

**YOU MAY USE THIS GRID TO HELP DETERMINE
WHICH SECTIONS IN THIS APPLICATION TO COMPLETE**

COMPLETE THE SECTIONS MARKED WITH AN "X"

Sections	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
<i>Adult Treatment Associate</i>	X	X		X	X	X	X	X														X	
<i>Adult Treatment Full</i>	X	X		X	X	X	X	X															
<i>Juvenile Treatment Associate</i>	X		X	X	X	X	X		X													X	
<i>Juvenile Treatment Full</i>	X		X	X	X	X	X		X														
<i>Adult Evaluator Associate</i>	X			X	X	X	X			X		X										X	
<i>Adult Evaluator Full</i>	X			X	X	X	X			X		X											
<i>Juvenile Evaluator Associate</i>	X			X	X	X	X				X		X									X	
<i>Juvenile Evaluator Full</i>	X			X	X	X	X				X		X										
<i>Adult Polygrapher</i>	X			X	X	X	X							X	X								X
<i>Adult Polygrapher Full</i>	X			X	X	X	X							X	X								
<i>Juvenile Polygrapher</i>	X			X	X	X	X							X	X								X
<i>Juvenile Polygrapher Full</i>	X			X	X	X	X							X	X								
<i>Adult DD Treatment</i>	X	X		X	X	X	X	X								X	X					X	
<i>Adult DD Evaluation</i>	X			X	X	X	X			X		X						X	X			X	
<i>Adult DD Polygrapher</i>	X			X	X	X	X							X	X					X	X		X

ALL applicants must complete a Standards of Practice section for each area of listing requested. Standards of Practice forms are contained in each categorized section.

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APPLICANT NAME:

DATE:

Provider #:
(SOMB use only)

Adult and Juvenile Re-Application:
For Continued Placement on the Sex Offender Management Board's Provider List as a Treatment Provider, Evaluator, and/or Polygraph Examiner.

Please check the category(ies) for which you are applying:

- ADULT TREATMENT PROVIDER**
___ FULL OPERATING LEVEL
___ ASSOCIATE LEVEL
___ DEVELOPMENTAL DISABILITIES SPECIALTY

- ADULT EVALUATOR**
___ FULL OPERATING LEVEL
___ ASSOCIATE LEVEL
___ DEVELOPMENTAL DISABILITIES SPECIALTY

- ADULT POLYGRAPH EXAMINER**
___ FULL OPERATING LEVEL
___ ASSOCIATE LEVEL
___ DEVELOPMENTAL DISABILITIES SPECIALTY

- JUVENILE TREATMENT PROVIDER**
___ FULL OPERATING LEVEL
___ ASSOCIATE LEVEL

- JUVENILE EVALUATOR**
___ FULL OPERATING LEVEL
___ ASSOCIATE LEVEL

- JUVENILE POLYGRAPH EXAMINER**
___ FULL OPERATING LEVEL
___ ASSOCIATE LEVEL

SECTION ONE
Background and Identifying Information:
Adult and Juvenile Re-Applicants

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

Applicant Name: _____
Credentials (MA, LCSW, etc) _____
Aliases: _____
Gender: Male Female Social Security Number: _____
Date of Birth _____ Colorado Driver's License Number _____
Employer or Business Name: _____

PLEASE NOTE THAT EMPLOYER NAME, ADDRESS AND PHONE INFORMATION IS USED FOR LISTING PURPOSES. FOR SAFETY REASONS, HOME ADDRESSES AND TELEPHONE NUMBERS ARE USED BY STAFF ONLY.

Primary Business Address: _____

County of Primary Location: _____
Telephone: _____ Fax: _____ E-mail: _____

You may list up to five addresses and/or counties on the provider list. Please list address, including **county**.

1. _____
2. _____
3. _____
4. _____
5. _____

Please list languages, other than English, which you speak fluently and in which you can demonstrate clinical proficiency (*this information will be published on the Provider List*):

Are you on the Approved Provider List of the Colorado Domestic Violence Offender Management Board (DVOMB)? _____ Yes _____ No

Have you submitted a fingerprint card to the DVOMB? _____ Yes _____ No
(You will not be required to submit new fingerprints if there is a current copy in your DV Provider file.)

Have you submitted a fingerprint card to the SOMB? _____ Yes _____ No
(You will not be required to submit new fingerprints if there is a copy in your SOMB Provider file.)

**Authorization for Release of Information:
*Adult and Juvenile Re-Applicants***

I, _____, authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to be on the Sex Offender Management Board's Provider List as one or more of the following: **Full Operating Level Treatment Provider, Associate Level Treatment Provider, Full Operating Level Evaluator, Associate Level Evaluator, Full Operating Level Polygraph Examiner, and/or Associate Level Polygraph Examiner.** I agree to give any further information that may be required in reference to my past record.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court association, or institutions having possession of any documents, records or other information pertaining to me, to furnish to the Sex Offender Management Board such information, including, but not limited to, documents and records, informal, pending or closed, or any other pertinent data and to permit the Sex Offender Management Board or any of its designated officers, committees, or staff to inspect and make copies of such documents, records and other information in connection with this application.

The foregoing authorization for release of information or records does not include consent for release of personal financial records, bank accounts, loans or other such personal information not related to my moral character, professional reputation, or fitness as a treatment provider and/or evaluator and/or polygraph examiner.

I hereby release, discharge and exonerate the Sex Offender Management Board, its agents and representatives, and any person furnishing such information from any and all liability of every nature and kind arising out of the furnishing of such information to other medical or professional societies or organizations, hospitals and hospital committees, and government agencies in the event that other such organizations and agencies present to the Sex Offender Management Board a release of authorization for release of information executed by me or a facsimile of such release or authority executed by me.

Signature of Applicant

Clearly Printed Applicant Name

Date

Adult and Juvenile Re-Applicants:

Please list your place(s) of employment and positions for the last five years starting with your current or most recent employment. If you practiced psychotherapy or polygraphy in another state, with or without a license, please also include that work experience. You may substitute a professional resume if it provides all the information requested.

You may copy this page

<i>Employer/Business Name:</i>	<i>Telephone:</i>
<i>Street Address:</i>	
<i>City:</i>	<i>State:</i> <i>Zip Code:</i>
<i>Position:</i>	<i>Dates of Employment:</i> <i>From</i> <i>To</i>
<i>Unless you were self-employed, list supervisor name:</i>	<i>Telephone:</i>
<i>If self-employed, provide the name of a professional reference to verify this employment:</i>	<i>Telephone:</i>
<i>Summary of job duties:</i>	
<i>Reason for leaving:</i>	

<i>Employer/Business Name:</i>	<i>Telephone:</i>
<i>Street Address:</i>	
<i>City:</i>	<i>State:</i> <i>Zip Code:</i>
<i>Position:</i>	<i>Dates of Employment:</i> <i>From</i> <i>To</i>
<i>Unless you were self-employed, list supervisor name:</i>	<i>Telephone:</i>
<i>If self-employed, provide the name of a professional reference to verify this employment:</i>	<i>Telephone:</i>
<i>Summary of job duties:</i>	
<i>Reason for leaving:</i>	

Adult and Juvenile Re-Applicants:

You may substitute a professional resume if it provides all the information requested.

ACADEMIC DEGREE	SPECIALTY AREA	DATE OF DEGREE	NAME OF COLLEGE OR UNIVERSITY	LOCATION-CITY & STATE
B.A./B.S.				
M.A., M.S., M.S.W.				
Ed.D.				
Ph.D.				
Psy.D.				
Psychiatric Clinical Nurse				
M.D.				
Board Certified:	___ Yes ___ No			
Other (describe)				

Adult and Juvenile Re-Applicants:

- Have you ever received a written reprimand at any place of employment?
 NO YES If yes, please explain.

- Have you ever been suspended, fired, or asked to resign from a position or employment?
 NO YES If yes, please explain. You may attach a statement if necessary.

- Have you ever been convicted of, or received a deferred judgment for, any offense involving criminal sexual or violent behavior?
 NO YES If yes, please explain.

- Have you ever been arrested, charged or convicted of any criminal offense?
 NO YES If yes, please explain.

- Have you ever been convicted of a felony?
 NO YES If yes, please explain.

Adult and Juvenile Re-Applicants for TREATMENT PROVIDER and EVALUATOR:

Reference: Adult and Juvenile Standards, sections 2.000, 3.000 and 4.000.

ALL APPLICANTS WHO ARE NOT LICENSED MUST BE REGISTERED WITH THE DATABASE FOR UNLICENSED PSYCHOTHERAPISTS IN ORDER TO BE PLACED ON THE SOMB PROVIDER LISTS EVEN IF THEIR CURRENT EMPLOYMENT DOES NOT REQUIRE IT.

- Do you have a current Colorado license to practice psychotherapy?
 NO **YES** (A copy of your license must be attached to this application sections 12-43-303; 12-43-403; 12-43-503; 12-43-603 C.R.S.)

If you are not licensed:

- a. Are you registered with the Database of Unlicensed Psychotherapists? (A copy of your registration must be attached to this application 12-43-702.5, C.R.S.) This requirement applies to ALL applicants, including DOC.
 NO **YES**
- b. Are you in the process of applying for a Colorado license?
 NO **YES**
- c. Have you practiced psychotherapy without a license in any other state?
 NO **YES** (If Yes, please list those states and include this experience in your employment history form.)

- Have you ever been licensed or certified to practice psychotherapy in any other states?
 NO **YES** (If Yes, please list those states and include this experience on the employment history page.)

- Have you ever been found to engage in unethical behavior by any licensing or certifying body in Colorado or any other state or jurisdiction?
 NO **YES** If yes, please explain.

- Have you ever had a license or certification revoked, canceled, suspended or have you 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.

NO **YES** If yes, please explain.

- Have you ever voluntarily relinquished a license or certification to provide psychotherapy?

NO **YES** If yes, please explain.

- Have you ever voluntarily or involuntarily limited, reduced or lost any clinical or mental health staff privileges?

NO **YES** If yes, please explain.

- Do you have any pending professional liability or malpractice actions, or final judgments or settlements involving your professional practice?

NO **YES** If yes, please explain.

SECTION TWO: Qualifications for Reapplication as Treatment Provider *Adult Applicants*

Reference: Standards, Sections 4.000

The following checklist will help you determine which level applies to you.

Associate Level	Full Operating Level
___ Professional mental health license or listed with DORA as unlicensed psychotherapist in good standing. [Section 4.300 (B)]	___ Licensed and in good standing with licensing board? [Section 4.400 (A)]
___ Face to face supervision hours specific to sex offender treatment and/or evaluation as calculated by graph in Section 4.310 (D).	
___ 600 hours of clinical experience, of which 300 hours must be face to face contact with sex offenders in past 3 years? [Section 4.310 (A)]	___ 600 hours of clinical experience, of which 300 hours must be face to face contact with sex offenders in past 3 years? [Section 4.410(B)]
___ 40 hours of training in the past 3 years? [Section 4.310(C)]	___ 40 hours of specialized training in the past 3 years? [Section 4.410 (C)]
___ No history of criminal sexual or violent behavior or felony which would bring into question competence or integrity to treat sex offenders? [Section 4.310 (E)]	___ No history of criminal sexual or violent behavior or felony which would bring into question competence or integrity to treat sex offenders? [Section 4.410 (E)]
<i>If the answers to ALL questions in the above column are YES, apply at the Associate Level. If not, go to the column on the right.</i>	<i>If the answers to ALL questions in the above column are YES, apply at the Full Operating Level.</i>

If you meet all of the previous criteria for Reapplication as Full Operating

Level Adult Treatment Provider, please submit the following:

- ❑ **\$100.00 money order made out to Colorado Department of Public Safety enclosed (REQUIRED).**
- ❑ **Evidence of licensure**

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If you meet all of the previous criteria for *Reapplication as Associate Level Adult Treatment Provider*, please submit the following:

- ❑ **\$100.00 money order made out to Colorado Department of Public Safety enclosed (REQUIRED).**
- ❑ **Evidence of registration with the Database of Unlicensed Psychotherapists or Licensure**

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SECTION THREE

Qualifications of Treatment Provider

Juvenile Applicants

Reference: Juvenile Standards, Sections 4.100 and 4.200

The following checklist will help you determine which level applies to you.

Associate Level	Full Operating Level
___ Either licensed or unlicensed and registered with the Database of Unlicensed Psychotherapists? [4.300 (B)]	___ Licensed? [Section 4.410 (A)]
___ 600 hours of supervised clinical experience with JVSO ¹ in past 3 years? [Section 4.310(A)]	___ 600 hours of clinical experience with JVSO ¹ in past 3 years? [Section 4.410(B)]
___ Face to face contact calculated pursuant to the grid located on page 61 in Section 4.310 (B).	___ 300 hours of face to face contact. [Section 4.310 (B)]
___ 40 hours of training in the past 3 years? [Section 4.310(C)]	___ 40 hours of training in the past 3 years? [Section 4.410 (C)]
___ No history of criminal sexual or violent behavior or felony which would bring into question competence or integrity to treat JVSO? [Section 4.310(E)]	___ No history of criminal sexual or violent behavior or felony which would bring into question competence or integrity to treat JVSO? [Section 4.410 (E)]

¹ JVSO refers to juveniles who have committed sexual offenses.
05/08

If you meet all of the previous criteria for Reapplication as Full Operating Level Juvenile Treatment Provider, please submit the following:

- **\$100.00 money order made out to Colorado Department of Public Safety enclosed (REQUIRED).**

- **Evidence of registration with the Database of Unlicensed Psychotherapists
OR
Evidence of licensure**

- **Applicant Category Page 1**

- **Section One – Background & Identifying Information..... 2**

- **Section Three – Qualifications of Treatment Providers: Juvenile 11**

- **Section Four – Statement of Understanding 14**

- **Section Five - References 15**

- **Section Six – Specialized Training 16**

- **Section Seven – Clinical Experience 17**

- **Section Nine – Standards of Practice for Treatment Providers:
Juvenile (including required attachments) 20**

If you meet all of the previous criteria for Reapplication as Associate Level Juvenile Treatment Provider, please submit the following:

- ❑ **\$100.00 money order made out to Colorado Department of Public Safety enclosed (REQUIRED).**
- ❑ **Evidence of registration with the Database of Unlicensed Psychotherapists**
- ❑ **Applicant Category Page..... 1**
- ❑ **Section One – Background & Identifying Information 2**
- ❑ **Section Three – Qualifications of Treatment Providers: Juveniles..... 11**
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- ❑ **Section Five - References..... 15**
- ❑ **Section Six – Specialized Training 16**
- ❑ **Section Seven – Clinical Experience 17**
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- ❑ **Section Twenty-one – Professional Supervision Agreement for Treatment
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SECTION FOUR

Statement of Understanding

Adult and Juvenile Re-Applicants

1. I understand that the information I have submitted on this application for the Sex Offender Management Board Provider List will be used for the following purposes:
 - A. To conduct criminal history checks and background investigations as necessary.
 - B. To create and disseminate a provider list of treatment providers, evaluators, and/or polygraph examiners.
2. My application materials will become a public record of the Division of Criminal Justice and may be subject to open record act requests pursuant to Section 24-72-304, C.R.S.
3. Inclusion on the 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 Provider List, it means that I am eligible to be considered as a provider of evaluation, assessment, treatment, and/or behavioral monitoring services for convicted sex offenders and/or adjudicated juveniles who have committed a sexual offense, pursuant to Section 16-11.7-106, C.R.S. which states:

“(1) The department of corrections, the judicial department, the division of criminal justice of the department of public safety, or the department of human services shall not employ or contract with and shall not allow a sex offender to employ or contract with any individual or entity to provide sex offender evaluation or treatment services pursuant to this article unless the sex offender evaluation or treatment services to be provided by such individual or entity conforms with the standards developed pursuant to Section 16-11.7-103(4) (b).”

(2) The board shall require any person who applies for placement on the list of persons who may provide sex offender treatment services pursuant to this article to submit a complete set of his or her fingerprints. The board shall forward any such fingerprints received pursuant to this subsection (2) to the Colorado bureau of investigation for use in conducting a state criminal history record check and for transmittal to the federal bureau of investigation for a national criminal history record check. The board shall use the information obtained from the state and national criminal history record check in determining whether to place the person on the approved provider list.
4. The Sex Offender Management Board will release information to all referring agencies regarding the status of my application, my placement on the Provider List, founded complaints, removal from the Provider List or denial of my application to the Provider List.
5. In the event a complaint is filed against me, the contents of my application will be reviewed by the Sex Offender Management Board in accordance with the Sex Offender Management Board Administrative Policies.
6. I have read the *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders and/or the Standards and Guidelines for the Evaluation, Treatment, and Supervision of Juveniles Who Have Committed Sexual Offenses and/or Standards for Community Entities That Provide Supervision and Treatment for Adult Sex Offenders Who Have Developmental Disabilities* in its entirety, and agree to carry out the *Standards* to the best of my ability related to the listing and level for which I am applying. I have answered all questions on this application honestly and the answers are complete to the best of my knowledge. I further understand that false statements or misstatements on this application are grounds for removal from the SOMB Provider Lists.

Signature of Applicant: _____ Date: _____

Printed Name of Applicant: _____

SECTION FIVE

References

Adult and Juvenile Re-Applicants

References

The individuals provided as references must be familiar with your professional qualifications. The references are divided into two sections (1A-3A are professional references and 1B-3B are MDT/CST members). Please note that at least two (2) of the references listed in 1B-3B must be members of a Community Supervision Team and/or Multidisciplinary Teams in which you participate. DOC/DYC employees please refer to * note below. Letters of reference are NO longer required as four of the following six references will be randomly contacted by our background investigator.

1A. Name:

Position:

Address:

Telephone number:

2A. Name:

Position:

Address:

Telephone number:

3A. Name:

Position:

Address:

Telephone number:

REQUIRED ADDITIONAL REFERENCES - These references must be familiar with your offense-specific work.

1B. PROBATION/PAROLE OFFICER

Name:

Address:

Telephone number:

2B. VICTIM ADVOCATE, THERAPIST, OR OTHER VICTIM PROFESSIONAL

Name:

Address:

Telephone number:

3B POLYGRAPH EXAMINER, TREATMENT PROVIDER, EVALUATOR, SUPERVISING OFFICER OR OTHER (Please indicate the individual's profession below)

Name:

Profession:

Address:

Telephone number:

* DOC/DYC EMPLOYEES: Since you may not be working with Community Supervision Teams and/or Multidisciplinary Teams you may provide names of co-workers or others familiar with your professional qualifications.

SECTION SIX

Specialized Training

Adult and Juvenile Re-Applicants

TREATMENT PROVIDER

(This form is required)

Specialized training is important to obtain since there is currently no graduate curriculum specialty area of sex offender treatment. In addition, higher education is a required aspect of the application and not considered specialized training. Although you may have received excellent clinical supervision, you may not use clinical supervision as "training." **Generally the length of the workshop or training equals hours of training.** FOR CONFERENCES, YOU MUST ITEMIZE EACH WORKSHOP ON A SEPARATE LINE.

**** Although you are no longer required to submit copies of your training certificates and/or agendas, you may be required to submit these upon request. The SOMB will randomly audit provider training certificates.**

Treatment Providers/Evaluators: designate in the last column below whether your training is counting towards Victim ("V"), Sex Offense Specific ("SOS"), Juvenile Treatment ("JT") or General Topic ("GT") hours (for juvenile providers) and "Treatment of Adult Sex Offenders ("ASO") for adult providers. ADULT NO LONGER HAS "GT" as a training category. (Evaluators, please use "E-SOS" for evaluation techniques). For Polygraph Examiners: designate which subject area each training counts towards as specified in 4.510 (B) and 4.610 (B).

You may copy this page.

DATES	HOURS	TITLE OF TRAINING	SPONSOR/TRAINER	Area: (e.g. "V", "SOS", "E-SOS", "GT" or "ASO")	Adult or Juvenile (e.g. "A", "J")
1/4/02	6	Offender Typologies	I. M. Atrainer, L.P.C.	SOS	

SECTION SEVEN

Clinical Experience

Adult and Juvenile Applicants

This form is to be used for documentation of the number of hours you have accumulated within the last three (3) years by providing treatment, evaluation, and/or polygraphs. Please refer to the Standards for the minimum number of required hours needed for the listing(s) for which you are applying. **Please only fill out the section that is relevant to which area you are applying for. If you are applying for both Adult and Juvenile, please fill out both sections.**

You may copy this page.

ADULT CLINICAL EXPERIENCE

DATES	# of hours, or # of evals.	CLINICAL ACTIVITY TYPE <i>(Group therapy, polygraph examinations, sex offense- specific evaluations, face to face, etc.)</i>	LOCATION or AGENCY
From:			
To:			
From:			
To:			
From:			
To:			
From:			
To:			

JUVENILE CLINICAL EXPERIENCE

DATES	# of hours, or # of evals.	CLINICAL ACTIVITY TYPE <i>(Group therapy, polygraph examinations, sex offense- specific evaluations, face to face, etc.)</i>	LOCATION or AGENCY
From:			
To:			
From:			
To:			
From:			
To:			
From:			
To:			

SECTION EIGHT

Standards of Practice for *Adult Treatment Providers*: Full Operating and Associate Level Applicants

Description of Sex Offense-Specific Treatment

Reference: Standards and Guiding Principles.

- Do you use group therapy as your primary modality of treatment with sex offenders?
 NO YES
 - a. Length of each session: 1 hour 1-2 hours More than 2 hours
 - b. Frequency of group sessions:
 Once a week Twice a week More than twice a week
 - c. Number of separate groups offered: _____
 - d. Are clients assigned any homework between sessions? NO YES
 - e. What is the average size of a treatment group? _____
 - f. What is the therapist/client ratio? _____
 - g. What time(s) of day do you offer treatment groups? _____
 - h. Are your treatment groups open or closed? Open Closed
 - i. What is the minimum length of time it takes a sex offender to complete your treatment program? _____
 - j. If group therapy is not your primary treatment modality, please describe your primary modality. _____

 - k. If you are a rural treatment provider and do not have enough referrals at one time to run a group, please indicate how you treat sex offenders in lieu of group.

 - l. Do you provide separate groups for male and female offenders? _____
 - m. Do you provide separate groups for those 18 and over, and under 18 years of age?

- In addition to your primary treatment modality previously listed, what other modalities of treatment do you use?
 - Group therapy
 - Family therapy
 - Victim clarification process
 - Substance abuse treatment
 - Referrals to self-help or 12 step programs
 - Other therapies for co-existing conditions
 - Support groups for families of sex offenders
 - Other (please explain) _____
 - Individual therapy
 - Partner therapy
 - Biomedical therapies
 - Referrals to psychiatrist
 - Domestic violence treatment

Attachments:

- a. Please attach copies of two (2) RECENT representative sex offense-specific treatment plans, with client identifying information *deleted*, that include the information required in Standards.
- b. Please attach a sample Treatment Contract. The contract provided should be specific to adult convicted sex offenders.
- c. Please attach a brief description of your program or the program you work for.

SECTION NINE

Standards of Practice for *Juvenile Treatment Provider:* Full Operating Level and Associate Level

Description of Sex Offense Specific Treatment

Reference: Juvenile Standards and Guiding Principles

- Which treatment modalities do you use?
 - Group therapy
 - Family therapy
 - Victim clarification process
 - Substance abuse treatment
 - Referrals to self-help or 12 step programs
 - Other therapies for co-existing conditions
 - Domestic violence treatment
 - Support groups for families of JVSO
 - Other (please explain) _____
 - Individual therapy
 - Partner therapy
 - Biomedical therapies
 - Referrals to psychiatrist

Attachments:

- a. Please attach copies of two (2) RECENT sex offense specific treatment plans for juveniles with client identifying information deleted, that include the information required in the Standards.
- b. Please attach a sample Treatment Contract/Advisement form containing the information required in the Standards.
- c. Please attach a brief description of your program.

SECTION TEN

Qualifications for Reapplication as Evaluator

Adult Applicant

Reference: Standards.

Associate Level Evaluators may be licensed or unlicensed, and must obtain ongoing clinical supervision from an Evaluator at the Full Operating Level. Providers may be listed on the Provider List at the Associate Level while they are seeking licensure or additional clinical experience, or may operate permanently at this level.

Full Operating Level Evaluators are licensed, may operate without ongoing clinical supervision specific to sex offender treatment, and may supervise Evaluators at the Associate Level, as well as students or other clinicians who have submitted an “Intent to Apply” form.

The following checklist will help you determine which level applies to you.

Qualifications for Reapplication as *Adult Evaluator*

Associate Level	Full Operating Level
___ 10 sex offense-specific evaluations within last 3 years? [Section 4.510 (A)]	___ Minimum of 20 sex offense-specific evaluations within last 3 years? [Section 4.610 (B)]
___ 10 of the 40 hours of specialized training shall be specific to the sex offense specific evaluation of adult sex offenders? [Section 4.510(B)]	___ 10 of the 40 hours of specialized training shall be specific to the sex offense specific evaluation of adult sex offenders? [Section 4.610 (C)]
___ No history of criminal sexual or violent behavior or felony which would bring into question the competence or integrity of the individual to provide sex offenses evaluations to sex offenders? [Section 4.510(E)]	___ No history of criminal sexual or violent behavior or felony which would bring into question the competence or integrity of the individual to provide sex offenses evaluations to sex offenders? [Section 4.610 (E)]
___ Face to face supervision hours specific to sex offender treatment and/or evaluation as calculated by graph in Section 4.510 (C).	___ Licensure or certification. [Section 4.610 (A)]
<i>If the answers to ALL the questions in the above column are YES, apply at the Associate Level. If not, go to the column on the right.</i>	<i>If the answers to ALL the questions in the above column are YES, apply at the Full Operating Level.</i>

*If you meet all of the previous criteria for **Reapplication as Adult Full Operating Level Evaluator**, please submit the following:*

- ❑ **\$100.00 money order made out to Colorado Department of Public Safety enclosed**
- ❑ **Evidence of licensure**

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*If you meet all of the above criteria for **Reapplication as Adult Associate Level Evaluator**, please submit the following:*

- ❑ **\$100.00 money order made out to Colorado Department of Public Safety enclosed**
- ❑ **Evidence of registration with the Database of Unlicensed Psychotherapists**

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Treatment Providers and Evaluators at the Associate Level 47**

SECTION ELEVEN

Qualifications of Evaluator

Juvenile Applicants

Reference: Juvenile Standards, Sections 4.500

The Juvenile Standards and Guidelines establish two levels of Evaluators who may be listed on the Provider List by the Sex Offender Management Board.

Associate Level Evaluators may be licensed or unlicensed, and must obtain ongoing clinical supervision from an Evaluator at the Full Operating Level. Providers may be listed on the Provider List at the Associate Level while they are seeking licensure or additional clinical experience, or may operate permanently at this level.

Full Operating Level Evaluators are licensed, may operate without ongoing clinical supervision specific to sex offender treatment, and may supervise Evaluators at the Associate Level, as well as students or other clinicians who have submitted an “Intent to Apply” form.

The following checklist will help you determine which level applies to you.

Qualifications for Reapplication as Juvenile Evaluator

Associate Level	Full Operating Level
	___ Either licensed or unlicensed and registered with the Database of Unlisted Psychotherapists? [Section 4.610 (A)]
___ Minimum of 10 sex offense specific evaluations in the last 3 years? [Section 4.501(A)]	___ Minimum of 20 sex offense specific evaluations in the last 3 years? [Section 4.610 (B)]
___ 10 of the 40 hours specialized training shall be specific to the sex offense specific evaluation of juveniles who have committed sexual offenses? [Section 4.510 (C)]	___ 10 of the 40 hours specialized training shall be specific to the sex offense specific evaluation of juveniles who have committed sexual offenses? [Section 4.610 (C)]
___ No history of criminal sexual or violent behavior or felony which would bring into question the competence or integrity of the individual to provide sex offenses evaluations of juveniles? [Section 4.510 (E)]	___ No history of criminal sexual or violent behavior or felony which would bring into question the competence or integrity of the individual to provide sex offenses evaluations of juveniles? [Section 4.610 (E)]
___ Face to face supervision hours specific to sex offender treatment and/or evaluation as calculated by graph in Section 4.500 (C). [Section 4.510(B)]	
<i>If the answers to ALL the questions in the above column are YES, apply at Associate Level. If not, go to the column on the right.</i>	<i>If the answers to ALL the questions in the above column are YES, apply at the Full Operating Level.</i>

If you meet all of the previous criteria for Reapplication as Juvenile Full Operating Level, please submit the following:

- **\$100.00 money order made out to Colorado Department of Public Safety enclosed**
- **Evidence of registration with the Database of Unlicensed Psychotherapists
OR
Evidence of licensure**
- **Applicant Category Page..... 1**
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(including required attachments)..... 31**

*If you meet all of the above criteria for **Reapplication as Juvenile Associate Level**, please submit the following:*

- **\$100.00 money order made out to Colorado Department of Public Safety enclosed**
- **Evidence of registration with the Database of Unlicensed Psychotherapists**
- **Applicant Category Page..... 1**
- **Section One – Background & Identifying Information 2**
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- **Section Six - Specialized Training 16**
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SECTION TWELVE

Standards of Practice for *Adult Evaluator*: Full Operating Level and Associate Level Applicants

Reference: Standards, Section 2.000 and Guiding Principles

- Approximately how many sex offense-specific evaluations have you conducted in the last five (5) years? _____. *Please document this information on the Clinical Experience Form.*
- Adhering to the established ethical standards, practices and guidelines of your profession, are you qualified and experienced to perform comprehensive sex offense specific evaluations examining the following areas?

- | | | |
|-----------------------------|------------------------------|--|
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Mental and/or organic disorders; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Drug/alcohol use; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Character pathology; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Stability of functioning; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Developmental history and competence; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Self-esteem and ego-strength; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Delinquency and conduct/behavioral issues; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Level of violence and coercion; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Level of deception and/or denial; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Assessment of risk including escalation of high-risk behavior; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Motivation and amenability for treatment; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Impact on the victim, when possible; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Treatment and supervision needs including informed supervision system and relapse prevention planning; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Community risk and protective factors; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Medical/neurological/ pharmacological needs; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Sexual evaluation, including sexual developmental history; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Deviant sexual arousal or interest in deviance/paraphilias (plethysmograph or Abel). |

If you answered NO to any area, how would you ensure that the area is included in the evaluation?

- Are you qualified to administer standardized psychological tests? NO YES
If NO, how would you ensure that such tests are conducted, if indicated?

Attachments:

- a. Please attach copies of two (2) sex offense-specific evaluations conducted on convicted adult sex offenders, with client identifying information deleted, that include the information required in Section 2.000.

SECTION THIRTEEN

Standards of Practice for *Juvenile Evaluator*: Full Operating Level and Associate Level

Evaluation and Ongoing Assessment of Juveniles Who Have Committed Sexual Offenses

Reference: Juvenile Standards, Section 2.000 and Guiding Principles

- Adhering to the established ethical standards, practices and guidelines of your profession, are you qualified and experienced to perform comprehensive sex offense specific evaluations examining the following areas?

- | | | |
|-----------------------------|------------------------------|--|
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Mental and/or organic disorders; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Drug/alcohol use; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Character pathology; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Stability of functioning; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Developmental history and competence; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Self-esteem and ego-strength; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Delinquency and conduct/behavioral issues; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Level of violence and coercion; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Level of deception and/or denial; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Assessment of risk including escalation of high-risk; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Motivation and amenability for treatment; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Family functioning levels; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Impact on the victim, when possible; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Treatment and supervision needs including informed supervision system and relapse prevention planning; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Community risk and protective factors; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Medical/neurological/ pharmacological needs; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Sexual evaluation, including sexual developmental history; |
| <input type="checkbox"/> NO | <input type="checkbox"/> YES | Deviant sexual arousal or interest in deviance/paraphilias (plethysmograph or Abel). |

If you answered NO to any area, how would you ensure that the area is included in the evaluation?

- Are you qualified to administer standardized psychological tests?
 NO YES

If NO, how would you ensure that such tests are conducted, if indicated?

Attachments:

- b. Please attach copies of two (2) RECENT sex offense specific evaluations of juveniles, with client identifying information deleted, that include the information required in Section 2.000.
- c. Please attach a sample consent/assent form containing the information required in the Standards.
- d. Please attach a brief description of your program.

SECTION FOURTEEN

Qualifications of Reapplication as Polygraph Examiner: *Adult and Juvenile Applicants*

Reference: Standards

Associate Level Polygraph Examiners provide polygraphs under the supervision of a Full Operating Level Polygraph Examiner.

Full Operating Level Polygraph Examiners provide polygraphs as part of a Community Supervision Team, may operate without ongoing supervision specific to polygraph examinations, and may supervise Associate Level Polygraph Examiners.

The following checklist will help you determine which level applies to you.

Associate Level Polygraph Examiner	Full Operating Level Polygraph Examiner
<input type="checkbox"/> Minimum of four (4) hours of one-to-one direct supervision monthly. [Section 4.710]	
<input type="checkbox"/> 40 hours of Specialized training in 3 years? [Section 4.720 (A)]	<input type="checkbox"/> 40 hours of Specialized training in 3 years? [Section 4.810 (A)]
<input type="checkbox"/> Written supervision agreement with a Full Operating Level Polygraph Examiner? [Section 4.710]	
<input type="checkbox"/> Conducted 75 criminal specific-issue exams in last 3 years? [Section 4.720 (B)]	<input type="checkbox"/> Conducted a minimum of 100 post-conviction sex offense specific issue exams? [Section 4.810 (B)]
<input type="checkbox"/> No conviction or deferred judgment for felony criminal sexual or violent behavior that would question the competence or integrity of the individual? [Section 4.720 (E)]	<input type="checkbox"/> No conviction or deferred judgment for felony criminal sexual or violent behavior that would question the competence or integrity of the individual? [Section 4.810 (E)]
<input type="checkbox"/> Quality assurance protocol from 3 separate polygraph examinations to three Full Operating Level Polygraph Examiners outside of Polygrapher's agency? [Section 4.720 (D)]	<input type="checkbox"/> Quality assurance protocol from 3 separate polygraph examinations to three Full Operating Level Polygraph Examiners outside of Polygrapher's agency? [Section 4.720 (D)]
<i>If ALL of your answers YES then apply at this level. If not, go to the column on the right.</i>	<i>If ALL of your answers YES then apply at this level.</i>

*If you meet all of the previous criteria for **Reapplication as Full Operating Level Polygraph Examiner Adult and/or Juvenile**, please submit the following:*

- ❑ **\$100.00 money order made out to Colorado Department of Public Safety enclosed (REQUIRED)**

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*If you meet all of the previous criteria for **Reapplication as Associate Level Polygraph Examiner Adult and/or Juvenile**, please submit the following:*

- ❑ **\$100.00 money order made out to Colorado Department of Public Safety enclosed (REQUIRED)**

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SECTION FIFTEEN

Standards of Practice for Polygraph Examiner: *Adult and Juvenile Applicants*

Reference: Adult and Juvenile Standards, 4.000

- ❑ Approximately how many polygraph examinations have you conducted with convicted adult sex offenders? _____
- ❑ Approximately how many polygraph examinations have you conducted with adjudicated juveniles who have sexually offended? _____
Please document the approximate number on the Clinical Experience form in this packet.

- ❑ Please describe below how you work with Community Supervision Teams and/or Multidisciplinary Teams:

Attachments:

- a. Please submit copies of two (2) polygraph examinations, including a narrative report, conducted on convicted adult sex offenders, and/or adjudicated juveniles who have sexually offended, with identifying client information deleted, and with hand and computer scored charts attached. If you are applying for both adult and juvenile polygrapher, please provide one examination conducted on a convicted adult sex offender and one on a juvenile who has sexually offended.
- b. Please submit documentation of your graduation from an accredited American Polygraph Association Program.
- c. _____ (Please initial) I understand that I shall engage in the peer review of my examinations by other polygraph examiners registered at the Full Operating Level biannually at a minimum as prescribed in Section 4.810 (D). Please submit the names and contact information of the Full Operating Level Polygraph Examiner(s) with whom you engage in peer review activities.

SECTION SIXTEEN

Qualifications of *Treatment Providers* reapplying as Specialty in Treatment of Sex Offenders with Developmental Disabilities (DD)

Please use this checklist to determine if you meet the conditions to reapply for the DD Specialty.

Associate Level Treatment Provider	Full Operating Level Treatment Provider
<p>___ 150 out of the required 600 hours of clinical contact with convicted sex offender must be with DD clients. 75 hours shall be direct face-to-face contact. [Section DD 4.310 (A)]</p>	<p>___ 150 out of the required 600 hours of clinical contact with convicted sex offenders must be with DD clients. At least half (75) being direct face-to-face [Section DD 4.410 (C)]</p>
<p>___ 10 out of the required 40 hours of specialized training must address aspects of working with DD sex offenders. [Section DD 4.310 (C)]</p>	<p>___ 10 out of the required 40 hours of specialized training must address aspects of working with DD sex offenders. [Section DD 4.410 (C)]</p>
<p>___ 25% of the required supervision per grid on page 52 of the Standards must be with a Full Operating Level DD Treatment Provider. [Section DD 4.310 (B)]</p>	

SECTION SEVENTEEN

Standards of Practice for *Treatment Providers* with a Specialty in Treatment of Sex Offenders with Developmental Disabilities (DD)

Reference: Standards, 3.000

Attachments:

- a. Please describe how your treatment of sex offenders with developmental disabilities differs from your treatment of sex offenders without developmental disabilities. Please limit your response to one page.
- b. Please attach at one (1) representative treatment plan, signed by you, conducted on a sex offender with developmental disabilities with all client identifying information deleted.
- c. Please attach copies of program materials that you have adapted for sex offenders with developmental disabilities.

SECTION EIGHTEEN

Qualification of *Evaluators* Reapplying as Specialty in the Evaluation of Sex Offenders with Developmental Disabilities (DD)

Reference: Standards, section DD4.500

Please use this checklist to determine if you meet the conditions to apply for the DD Specialty.

Associate Level Evaluator	Full Operating Level Evaluator
___ 25% of the required supervision per grid on page 62 of the Standards must be with a Full Operating Level DD Treatment Provider [Section DD 4.510 (C)]	
___ 10 of the 40 required hours of specialized training must address aspects of working with DD sex offenders. [Section DD 4.510 (B)]	___ 10 of the 40 required hours of specialized training must address aspects of working with DD sex offenders. [Section DD 4.610 (C)]
___ 2 of the 10 required offense specific evaluations shall be completed on adult sex offenders with developmental disabilities. [Section DD 4.510 (A)]	5 of the 20 required offense specific evaluations shall be completed on adult sex offenders with developmental disabilities. [Section DD 4.610 (B)]

SECTION NINETEEN

Standards of Practice for *Evaluators* with a Specialty in the Evaluation of Sex Offenders with Developmental Disabilities (DD)

Attachments:

- a. Please describe how your mental health sex offense-specific evaluations of sex offenders with developmental disabilities differ from your mental health sex offense-specific evaluations of sex offenders without developmental disabilities. Please limit your response to one page.
- b. Please attach a copy of one (1) representative evaluation for a sex offender with developmental disabilities. Please delete all identifying client information
- c. Please attach copies of program materials that you have adapted for sex offenders with developmental disabilities

SECTION TWENTY

Qualifications of *Polygraph Examiners* Reapplying as a Specialty in Sex Offenders with Developmental Disabilities (DD)

Please use this checklist to determine if you meet the conditions to apply for the DD Specialty.

Associate Operating Level Polygraph Examiner	Full Operating Level Polygraph Examiner
___ Must have a supervisor with a specialty in examining sex offenders with DD.	
___ 18 of the 75 required polygraph exams must be with DD sex offenders [Section DD 4.720 (B)]	___ 25 of the 100 required polygraph exams must be with DD sex offenders [Section DD 4.810 (B)]
___ 10 of the 40 required hours of specialized training must address aspects of working with DD sex offenders [Section DD 4.720 (A)]	___ 10 of the 40 required hours of specialized training must address aspects of working with DD sex offenders [Section DD 4.810 (A)]

SECTION TWENTY ONE

Standards of Practice for *Polygraph Examiners* with a Specialty in Sex Offenders with Developmental Disabilities (DD)

Attachments:

- a. Please describe how your polygraph examinations of sex offenders with developmental disabilities differ from your polygraph examinations of sex offenders without developmental disabilities. Please limit your response to one page.
- b. Please attach a copy of one (1) representative polygraph examination for a sex offender with developmental disabilities. Please delete all identifying client information.

SECTION TWENTY TWO
Professional Supervision Agreement For Associate
Level Treatment Providers and/or Evaluators:
Adult and Juvenile Applicants

You may copy this page.

Applicants Name: _____
Date: _____

Supervisor's Name: _____
Agency: _____
Address: _____
City, State, Zip _____
Telephone: _____
Fax: _____ Email: _____

Please note, supervision shall not be provided by a relative of the applicant.

I, _____ do hereby verify that I have provided _____ hours
(Supervisor) (#)
of face-to-face supervision to the above named applicant. I have provided _____ hours
(#)
of face-to-face co-therapy in the same room. These hours were accumulated in accordance
with the Standards and were provided at: _____

(Agency Name)

In signing this agreement, we verify that we will accumulate the required supervisory hours
as prescribed in the Standards. This supervision will consist of approximately _____ hours a
month of supervision directly related to sex offense specific treatment/evaluation and will
include the following types of supervision (*please specify activities*): _____

Supervisor's signature _____ Date _____

Applicant's signature _____ Date _____

SECTION TWENTY THREE
Professional Supervision Agreement For Associate
Level Polygraph Examiners:
Adult and Juvenile Applicants

You may copy this page.

Applicants Name: _____
Date: _____

Supervisor's Name: _____
Agency: _____
Address: _____
City, State, Zip _____
Telephone: _____
Fax: _____ Email: _____

Please note, supervision shall not be provided by a relative of the applicant.

I, _____ do hereby verify that I have provided _____ hours
(Supervisor) (#)
of supervision. These supervision hours were provided at: _____

_____ (Agency Name)
between _____ and _____
(Start Date) (End Date or Today's Date)

I hereby verify that I have signed off on _____ polygraphs conducted by the applicant
(#)

In signing this agreement, we verify that we will accumulate the required supervisory hours
as prescribed in the Standards.

Supervisor's signature _____ Date _____

Applicant's signature _____ Date _____