|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | DEPARTMENT OF SOCIAL AND HEALTH SERVICES  DOMESTIC VIOLENCE INTERVENTION TREATMENT (DVIT) PROGRAM  **Add or Remove a Service for an Existing  DVIT Certification** | | | | |
| All forms must be signed and filled out completely. Incomplete forms will not be accepted. See Washington Administrative Code (WAC) 388-60B for Domestic Violence Intervention Treatment (DVIT) Program standards. There is no fee for filing this application.  **Submit the completed application and supporting documents to:**  Department of Social and Health Services (DSHS)  Domestic Violence Intervention Treatment Program Certification  PO Box 45470  Olympia, WA 98504-5470 | | | | | |
| **Program Information** | | | | | |
| PROGRAM NAME | | | | | TELEPHONE NUMBER (WITH AREA CODE) |
| MAILING ADDRESS CITY STATE ZIP CODE | | | | | |
| PHYSICAL ADDRESS CITY STATE ZIP CODE | | | | | |
| DIRECTOR’S NAME | | TELEPHONE NUMBER (WITH AREA CODE) | | | EMAIL ADDRESS |
| **Adding a Domestic Violence Intervention Treatment Service** | | | | | |
| Please select all treatment services this program is applying to **add**:  Domestic violence behavioral assessments  Levels 1, 2, and 3 domestic violence intervention treatment  Level 4 domestic violence intervention treatment  List the name of the supervisor who will facilitate all Level 4 treatment:  ; and  Check here to indicate you have attached documentation of their initial six-hour Level 4 training and a completed Level 4 questionnaire.  Check here to indicate that you have attached all applicable policies and procedures with this application to provide any new services, as outlined in WAC 388-60B-0115. | | | | | |
| **Removing a Domestic Violence Intervention Treatment Service** | | | | | |
| Please select all treatment services this program would like to **remove** from its existing certification::  Domestic violence behavioral assessments  Levels 1, 2, and 3 domestic violence intervention treatment  Level 4 domestic violence intervention treatment | | | | | |
| **Attestation** | | | | | |
| I certify under penalty of perjury that the information provided in this application for certification is true and correct. I understand that any material misrepresentation or misstatement of fact may result in sanctions, including the denial or loss of program certification. | | | | | |
| DIRECTOR’S SIGNATURE DATE | | | | PRINT DIRECTOR’S NAME | |
| **For Department of Social and Health Services Use Only** | | | | | |
| APPROVED BY: | | | Certified from:  to: | | |
| DSHS STAFF SIGNATURE DATE | | | | PRINT STAFF NAME | |