DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DOMESTIC VIOLENCE INTERVENTION TREATMENT (DVIT) PROGRAM

Application for Renewal Program 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. The application fee is $125.

Submit the fee, 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	
IF YOU ARE THE SOLE PRACTITIONER AT THIS PROGRAM, PLEASE LIST YOUR EMERGENCY CONTACT PERSON NAME	TELEPHONE NUMBER (WITH AREA CODE)	EMAIL ADDRESS	

Off-Site Locations

If applicable, please list all off-site locations (including addresses) where your program will provide domestic violence intervention treatment services (e.g., jails):

Domestic Violence Intervention Treatment Services

Please select all treatment services your program is applying to provide:

- ☐ Domestic violence behavioral assessments
- ☐ Levels 1, 2, and 3 domestic violence intervention treatment
- ☐ Level 4 domestic violence intervention treatment
- ☐ Will you be providing any of the above services online?

Direct Treatment Staff

Please list all direct treatment staff.

NAME	STAFF LEVEL REQUESTED (TRAINEE, STAFF OR SUPERVISOR)	DSHS FORM 10-210, BACKGROUND CHECK AND DOH CREDENTIAL ATTACHED.	HAS THIS PERSON BEEN PARTY TO ANY CIVIL PROCEDINGS INVOLVING DV OR CRIMES OF MORAL TURPITUDE?
		☐ **Yes**	☐ Yes ☐ No
		☐ **Yes**	☐ Yes ☐ No
		☐ **Yes**	☐ Yes ☐ No
		☐ **Yes**	☐ Yes ☐ No
		☐ **Yes**	☐ Yes ☐ No

Application Documentation Checklist

Each applicable item listed in this section must be checked and submitted with this application:

- ☐ $125 application fee.
- ☐ A copy of the current business license for this program, or its governing agency, to conduct business at the physical address on this application (except for programs operating on tribal land, city, or other government agencies).
- ☐ A current DOH license as a licensed or registered counselor, and the results of current criminal history background checks for each direct treatment staff, conducted in each state the person has lived in for the last 10 years.
- ☐ If applicable, a copy of the case identification or legal findings and the staff person's written explanation if they have any civil proceedings involving domestic violence or crimes of moral turpitude.
- ☐ A statement of qualifications for any staff added since the last certification period (DSHS form 10-210).
- ☐ All continuing education hours for each direct treatment staff (DSHS form 14-544).
- ☐ If the program's policies and procedures have already been approved, but is applying to provide any new service, the program must submit all new applicable policies and procedures as listed in WAC 388-60B-0115.

Treatment Modalities

Please describe your program's evidence-based or promising practice treatment modalities (e.g., cognitive behavioral) and methods of treatment (e.g. groups and individual sessions) below:

Treatment Level 4

If the program is applying to provide Level 4 treatment, provide the name of the supervisor who will facilitate group and individual treatment sessions and attach a copy of the documentation of the required six-hour training and questionnaire.

SUPERVISOR'S NAME	☐ Documentation of six-hour training and questionnaire are attached.

Cooperative and Collaborative Relationships

Each item listed in this section must be checked and submitted with this application.

☐ One item of documentation demonstrating a cooperative relationship with another program or agency involved in the provision of direct or ancillary services related to domestic violence:

NAME OF PROGRAM OR AGENCY (I.E., PROBATION SERVICES)	TYPE OF DOCUMENTATION (I.E., LETTER)

☐ One item of documentation, for each service area, demonstrating the program regularly attends and participates in the local DV task force, intervention committee or coordinated community response group if one exists in the community:

☐ Check here if this is not applicable in all of your service area communities.

NAME OF SPONSORING PROGRAM (I.E., YWCA)	TYPES OF DOCUMENTATION (I.E., LETTER)

☐ Collaboration (electronic or in-person) with at least one other Washington State certified domestic violence intervention treatment program

CERTIFIED DVIT PROGRAM	CONTACT PERSON
TELEPHONE NUMBER (WITH AREA CODE)	EMAIL ADDRESS
REGULARLY SCHEDULE MEETING DAY (I.E., 1ST MONDAY EACH MONTH)	TIME

Attestation

Our program complies with the following sections of Washington Administrative Code (WAC) 388-60B.
If yes, check all applicable boxes:

- ☐ WAC 388-60B-0045 ..... Program Records
- ☐ WAC 388-60B-0015 through 0125 ..... Policies and Procedures, Facility and Quality Management
- ☐ WAC 388-60B-0200 through 0280..... Direct Treatment Staff
- ☐ WAC 388-60B-0300 through 0370..... Program and Participant Standards
- ☐ WAC 388-60B-0400 through 0435 ..... Treatment Requirements

By signing this application, our program acknowledges and consents to on-site reviews of any and all documents pertaining to the delivery of domestic violence intervention treatment services, including but not limited to, policies and procedures, personnel records, quality management, facility, and clinical record reviews. Our program agrees to make all records available for the purpose of determining WAC compliance by DSHS staff responsible for the certification of domestic violence intervention treatment programs. Furthermore, 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

Check deposited on:	Certified from:	to:
DSHS STAFF SIGNATURE	DATE	PRINT STAFF NAME