CHILDREN'S ADMINISTRATION
DOMESTIC VIOLENCE PERPETRATOR TREATMENT PROGRAM

Application for Renewal Program Certification

All forms must be filled out completely. Incomplete forms will not be accepted. The application fee is $100

Submit the completed application and supporting documents to:

Department of Social and Health Services (DSHS)
Children's Administration
Domestic Violence Perpetrator Treatment Program Certification
PO Box 45710
Olympia, WA 98504-5710

OR send via a secure email to: CADVProgram@dshs.wa.gov

PROGRAM NAME			TELEPHONE NUMBER (AND AREA CODE) FAX NUMBER (AND AREA CODE)
MAILING ADDRESS	CITY	STATE	ZIP CODE
PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
DIRECTOR'S NAME	EMAILCONTACT		

List the names of all direct treatment staff:

NOTE: The program MUST submit a completed and signed Staff Statement of Qualifications form (DSHS 10-210) for each person listed below.

NAME	STAFF LEVEL REQUESTED (SUPERVISOR, STAFF OR TRAINEE)	FOR DSHS USE ONLY	
		APPROVED	DATE
		☐	
		☐	
		☐	
		☐	
		☐	

Application documentation checklist:

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

☐ $100 application fee.

☐ A **completed** and **signed** Staff Statement of Qualifications form (DSHS 10-210) for each person listed above.

☐ Results of current criminal history background checks for each person listed above, conducted by the Washington State Patrol.

☐ Proof that each direct treatment staff is registered as a counselor with the WA State Department of Health (a copy of each person's license).

☐ An update of continuing professional education hours for each direct treatment staff (DSHS 10-544).

Application documentation checklist (continued):

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

☐ **Three** items of evidence that the program has established and continues to maintain **cooperative relationships** with local domestic violence victim programs and other local agencies involved with domestic violence intervention:

ITEM OF EVIDENCE	NAME OF PROGRAM OR AGENCY (I.E., YWCA)	TYPE OF EVIDENCE (I.E., LETTER)
☐ **1**		
☐ **2**		
☐ **3**		

☐ Documentation that the program has established a **referral process** between the program and the local domestic violence victim services programs.

NAME OF PROGRAM OR AGENCY (I.E., YWCA)	TYPE OF EVIDENCE (I.E., LETTER)

☐ Proof (i.e., letter) that the program participates in a local domestic violence task force, intervention committee or workgroup if one exists in the community. ☐ Check here is this is not applicable in your community.

Attestation section:

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

☐ WAC 388-60-0045 .....Treatment focus
☐ WAC 388-60-0075 .....Treatment modality
☐ WAC 388-60-0065 thru 0305 ...Program policies and procedures
☐ WAC 388-60-0315 thru 0395.....Treatment staff qualifications
☐ WAC 388-60-0405 .....Orientation and continuing professional education requirements
☐ WAC 388-60-0455 .....Knowledge of law and justice system practices
☐ WAC 388-60-0425 .....Cooperation with domestic violence victim programs

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 perpetrator treatment services, including but not limited to, policies and procedures, personnel records, 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 perpetrator 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