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|  | 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 | | | | | | | | | |
| **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 this program was previously certified under WAC 110-60 and this is the first renewal application since the adoption of WAC 388-60B, the program must also submit a copy of all applicable policies and procedures as listed in WAC 388-60B-0115.  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 demonstrating the program regularly attends and participates in a 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 your community. | | | | | | | | | |
| NAME OF SPONSORING PROGRAM (I.E., YWCA) | | | | | | TYPE 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 | | |