

**State of Nevada**  
**Committee on Domestic Violence**

100 N. Carson St, Carson City, Nevada 89701-4717  
Phone (775) 684-1223 Fax (775) 684-1145

**Application for Renewal of Certification**

Please complete the following information for the certification year, pursuant to NAC 228.125.

**Program Contact Information**

Program Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street / P.O. Box City State Zip

Email Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
(Location #1) Street / P.O. Box City State Zip

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
(Location #2) Street / P.O. Box City State Zip

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

For additional locations, please attach separate sheet. Additionally, please contact this board to update contact information as needed.

**Program Certification Information**

Original Certification Date: \_\_\_\_\_

Last Certification Expiration Date (Attach copy of last certificate): \_\_\_\_\_

**Program Financial Information**

What percentage of batterers treatment clients at this program are indigent? \_\_\_\_\_  
(NAC 228.106 requires that at least 5 percent of the offenders accepted by the program are indigent)

Does this program use a sliding fee scale?      Yes      No  
(NAC 228.106 requires that programs determine the ability of an offender to pay for the program and charges the offender a fee based on a sliding scale that enables the offender to pay for the program, and requires that the program not deny an offender participation solely because of inability to pay for the program)

Current copy of sliding fee scale attached.

**Program Client Information**

Average number of clients enrolled in each group: \_\_\_\_\_

Number of clients currently enrolled in your program: \_\_\_\_\_

Total number of clients enrolled/served in the past year: \_\_\_\_\_

Number of court-ordered/referred clients in the past year: \_\_\_\_\_

Number of court-ordered/referred clients completing program in the past year: \_\_\_\_\_

**Program Supervisor Information** (Please attach additional sheets if your agency has multiple supervisors)

Supervisor's Name: \_\_\_\_\_

Supervisor's License #: \_\_\_\_\_ MFT    LCSW    LPC    Waiver

Date Supervisor Was Approved By Committee: \_\_\_\_\_

Current copy of pertinent license attached

Documentation of required 15 hours continuing education units attached

**Program Provider Information** (Any new providers require the Approval of New Provider Form including documentation of ALL formal training and observation hours).

List any changes to your staff since the last renewal application.

_____	_____
_____	_____
_____	_____

**Program Legal Information** (If any of the following questions are answered "yes" please provide a written detailed explanation of the circumstances and outcome).

Since the date of your program's original certification:

1. Have you or any of your staff been indicted or convicted of a felony?  
Yes            No
2. Have you or any of your staff been convicted of any crime involving domestic violence?  
Yes            No
3. Have you or any of your staff been convicted of any crime involving substance abuse?  
Yes            No
4. Have you or any of your staff been sued or charged with ethics violations?  
Yes            No
5. Have you or any of your staff been convicted of a crime which demonstrates unfitness to act as a provider or supervisor of treatment?  
Yes            No

**Declaration**

I hereby declare, under penalty of perjury, that all information provided and attached to this application is to the best of my knowledge true, accurate and complete and I have not withheld, misrepresented, or falsely stated any information relevant to this application.

\_\_\_\_\_  
Print Name of Program Supervisor

\_\_\_\_\_  
Original Signature of Program Supervisor

\_\_\_\_\_  
Date

***You must fill out this form in its entirety and check this box to indicate that you are aware that incomplete applications will NOT be considered and may be returned to you.***

**Supervision Schedule**

NAC 228.115 requires that the supervisor of treatment meet individually at least once each month with each provider of treatment he supervises. Mark an "x" under each month that you have met with each indicated provider.

Name of Provider	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.

**Explanations:** If you have not met monthly with each provider, please explain below.

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**Telephone availability:** NAC 228.115 requires that the supervisor be available by telephone to consult with each provider of treatment he supervises.

Are you available by telephone to consult with each provider you supervise? Yes      No

**10% Audit for Completeness of Client Files**

NAC 228.115 requires that supervisors review a random sample of at least 10 percent of the records of the offenders who are receiving treatment from each provider of treatment he supervises. Complete this form each month, and attach all forms for the year to your renewal packet.

**Month:** \_\_\_\_\_

**Number of offenders provided service** \_\_\_\_\_ **Number of files reviewed** \_\_\_\_\_

Were 10 percent of the records from each provider reviewed? Yes      No

**File Review Results**

<u>Requirement:</u>	<u>100%-95%</u>	<u>95%&lt;</u>	<u>Below 80%</u>
Consent to Service Signed	_____	_____	_____
Treatment Plan Completed	_____	_____	_____
Lethality Checklist Completed	_____	_____	_____
Release to Judge Signed	_____	_____	_____
Release to Partner/Collateral	_____	_____	_____
Group Case Notes Completed	_____	_____	_____
Homework in Client File	_____	_____	_____
Court-Reports Mailed	_____	_____	_____
Follow-up Form Completed	_____	_____	_____
Police Report Obtained	_____	_____	_____

**Corrections:** Detail how your program intends to address any deficiencies noted above.

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### Supervisor Group Observation

NAC 228.115 requires that supervisors observe, at least once every three months, a group counseling session conducted by each team of two provider of treatment he supervises. Therefore, each team listed on page 5 of this application should have 4 group observation forms. **If for any reason, there are not 4 group observation forms for each team listed on page 5, you must attach a detailed explanation.**

Provider Team Names: \_\_\_\_\_ and \_\_\_\_\_

Topic of group: \_\_\_\_\_ Observation date: \_\_\_\_\_

**Observation of providers while co-facilitating groups: How well do the providers adhere to NAC228 including degree of compliance with program content, avoidance of victim blaming, reinforcing perpetrator accountability? How effectively do the providers interact with each other? Attach additional sheets if necessary.**

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#### Group strengths:

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#### Group weaknesses:

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#### Suggestions for improvement:

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Check this box if you have discussed the contents of this observation with the above providers.

**Supervisor's Annual Performance Report  
Domestic Abuse Treatment Provider**

NAC 228.115 requires that the supervisor prepare an annual report concerning the performance of each provider of treatment he supervises.

**Provider Information**

Provider Name: \_\_\_\_\_

Date Provider Was Approved By Committee: \_\_\_\_\_

**Does your agency have proof on file that this provider is qualified pursuant to NAC 228.110? Yes No**  
**Has this provider completed 15 hours of continuing education units for this renewal period? Yes No**  
Proof of required continuing education attached.

**Observation of provider while co-facilitating groups: How well does the provider adhere to the NAC228 including degree of compliance with program content, avoidance of victim blaming, reinforcing perpetrator accountability? How effectively does provider interact with co-facilitator? Attach additional sheets if necessary.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Goals:**

\_\_\_\_\_  
\_\_\_\_\_

**Sensitivity to Survivor Issues:**

\_\_\_\_\_  
\_\_\_\_\_

**Ability to address "labeling" issues:**

\_\_\_\_\_  
\_\_\_\_\_

**Ability to address "collusion" issues:**

\_\_\_\_\_  
\_\_\_\_\_

_____ Original Signature of Provider	_____ Date
_____ Original Signature of Program Supervisor	_____ Date

**CEU Log**

Individuals are allowed to obtain up to one-half (7.5 credits) of the required continuing education via distance media. Individuals providing services in rural areas are allowed to obtain up to 10 credits via distance media.

Courses not yet approved by the Committee must be submitted for review on an **Application for Training Credits**.

NAC228.210 does not allow credit to be given for taking the same course two years in a row.

**Current year continuing education:** List continuing education credits being used for this renewal application period (the twelve months preceding the date of the last application expiration).

Name of Provider or Supervisor \_\_\_\_\_

Title of Course	Number of Credits	Date Course was Approved	Distance Media	
			Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

Name of Provider or Supervisor \_\_\_\_\_

Title of Course	Number of Credits	Date Course was Approved	Distance Media	
			Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

Name of Provider or Supervisor \_\_\_\_\_

Title of Course	Number of Credits	Date Course was Approved	Distance Media	
			Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

**Certificates for required continuing education must be attached.**