State of Nevada
Committee on Domestic Violence

555 E. Washington Ave., Suite 3900, Las Vegas, NV 89101
Phone (702) 486-5714 Fax (702) 486-3768

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.

_____

_____

_____

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

Requirement:	100%-95%	95%<	Below 80%
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.

_____

_____

_____

_____

_____

_____

_____

Day/Time/Provider Team Information

Provider Team	Days/Times/Type of Groups
Example: John Smith and Jane Doe	Mondays 9 am (men) and 6 pm (women) Thursday 4 pm (Spanish men)
John Smith and Sarah Johnson	Wednesday 4 pm (men)

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.

Group strengths:

Group weaknesses:

Suggestions for improvement:

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

Name of Provider or Supervisor____

Title of Course	Number of Credits	Date Course was Approved	Distance Media
____________________	__________	________________	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

Certificates for required continuing education must be attached.