

**INITIAL CERTIFICATION APPLICATION
INFORMATION AND INSTRUCTIONS
IDAHO SEXUAL OFFENDER
TREATMENT PROVIDER – JUVENILE CLIENTS**

Procedures for Idaho Sexual Offender Treatment Provider Certification for juvenile clients are now in

effect. Please note the following:

- Idaho Certified Treatment Providers must maintain at least masters-level professional licensure in a mental health field, or as a medical doctor in the state in which they provide services. Provisional/Supervised-level providers are required to be in the process of obtaining their masters-level professional licensure if they aren't already licensed.
- The application processing fee for initial certification is \$75 for Senior/Approved and Associate/Supervised level treatment providers. The application processing fee for Provisional/Supervised level providers is \$50. Treatment providers who also wish to be certified as psychosexual evaluators will be assessed a separate application processing fee for each provider type. Only checks or money orders made payable to the Sexual Offender Management Board can be accepted.
- Certification approval applies to work with either adult clients or juvenile clients. Separate certification applications must be submitted for each population served.
- An attachment checklist can be found on the last page of the application to assist you in ensuring that required documentation is included.
- Information about provider qualifications and treatment service standards is located in the SOMB's Standards and Guidelines for Practitioners, Evaluations and Treatment of Juvenile Sexual Offenders which are posted on the SOMB's website (<http://somb.idaho.gov>).

Rosters for certified providers are posted on the SOMB's website. If you wish to be included for service districts other than the location of your practice's office, please indicate the additional service districts on the application.

The SOMB typically meets on the 2nd Friday of each month. To be considered for certification review during any given month, your completed application and any required supporting documentation must be received by the SOMB no less than 30 days prior to a regularly scheduled meeting date.

Please mail your completed application and attachments to:

**SOMB Application
Attn: Accounts Receivable
Idaho Department of Correction
1299 N Orchard St, Ste 110
Boise, ID 83706**

Questions may be directed to the SOMB office.

SEXUAL OFFENDER MANAGEMENT BOARD
IDAHO DEPT. OF CORRECTION
1299 N. ORCHARD ST. STE 110 ♦ BOISE, ID ♦ 83706
TEL: (208) 658-2002 ♦ FAX: (208) 287-3322

FOR OFFICE USE ONLY	
DATE RECEIVED	ISSUANCE DATE
CERTIFICATE #	

IDAHO SEXUAL OFFENDER TREATMENT PROVIDER INITIAL CERTIFICATION APPLICATION – JUVENILE SERVICES

Check All That Apply:

<input type="checkbox"/> Senior/Approved Treatment Provider	<input type="checkbox"/> Reciprocity Consideration
<input type="checkbox"/> Associate/Supervised Treatment Provider	<input type="checkbox"/> Conditional Waiver
<input type="checkbox"/> Provisional/Supervised Treatment Provider	

Please Type or Print Clearly – Carefully follow all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all supporting documents. Failure to do so could result in a delay in processing or denial of your application. **Refer to the certification requirements and application procedures outlined in the Idaho SOMB's Standards and Guidelines for Practitioners, Evaluations and Treatment of Juvenile Sexual Offenders.**

DEMOGRAPHIC INFORMATION

Applicant's Name: Last		First	Middle Initial
Business Name & Address 1		Telephone	
City		State	ZIP
Mailing Address if Different From Above		Alternate Telephone	
City		State	ZIP
Business Name & Address 2		Telephone	
City		State	ZIP
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	E-mail Address	
List Any Other Names You Have Been Known Under			
Which Judicial Districts Would You Like to be Listed Under on the Sexual Offender Treatment Provider Roster?			

LICENSURE INFORMATION

Current and Previous Licensure or Certification – List all states where certificates or licenses are or were held. Specifically list certificates or licenses granted as temporary, reciprocity, exemption or similar, with type, date, grantor, and if certificates or license is current.

State/ Jurisdiction	Profession	Grantor	Certificate or License		Permanent, Temporary or Other: explain	Currently Valid (please explain if not valid)
			Yr Issued	Number		

State/ Jurisdiction	Profession	Grantor	Certificate or License		Permanent, Temporary or Other: explain	Currently Valid (please explain if not valid)
			Yr Issued	Number		

EDUCATION INFORMATION

Highest degree earned _____ Year _____
 In the spaces below, provide a chronological listing of your post-secondary and post-graduate training. (Attach additional sheet if necessary.)

Full Name, City and State Schools Attended	Attendance		Date Graduated	Degree Earned	Major Area of Study	If No Degree, # of Semester/Qtr Hrs Earned
	Entrance Date	Ending Date				

PROFESSIONAL EXPERIENCE

List all professional experience in chronological order. (Exclude activities listed under other sections.) (Attach additional sheet if necessary.)

Indicate Nature of Experience or Practice and Location	Inclusive Dates of Experience	
	Beginning Date	Ending Date

PROFESSIONAL EXPERIENCE/SPECIALIZED TRAINING REQUIREMENT

Senior/Approved Sexual Offender Treatment Provider:

- 1. You must have completed a combination of direct clinical practice with juvenile sexual offenders and specialized training for a minimum of 1500 hours within the 3 years immediately preceding this application.
- 2. Of the 1500 hour clinical practice and specialized training requirement:
 - a. At least 500 hours in sexual offender treatment experience;
 - b. May include clinical practice hours in juvenile sexual offender assessment and evaluation;
 - c. A minimum of 60 hours or a maximum of 375 hours in sexual offender-specific specialized training;
 - i. No more than 16 training hours may be attributed to the treatment of sexual abuse victims.

Examples:

Sexual offender treatment	700 hours
Specialized training	375 hours
Psychosexual evaluations	<u>425 hours</u>
Total:	1500 hours

Or:

Sexual offender treatment	1440 hours
Specialized training	<u>60 hours</u>
Total:	1500 hours

- 3. On another sheet, please provide the name(s), address(s) and telephone number(s) of the supervising agency and/or agency for which you worked. Describe your duties with the agency. Please also describe how the required hours were acquired and include substantiating documentation.

- Do you have at least 500 face-to-face hours in juvenile sexual offender treatment? Yes No
- Do you have at least 60 hours of sexual offender-specific specialized training? Yes No
- Do you have a minimum total of 1500 hours of training and experience related to juvenile sexual offenders? Yes No

Associate/Supervised Sexual Offender Treatment Provider:

- 1. You must have completed a combination of direct clinical practice with juvenile sexual offenders and specialized training for a minimum of 500 hours within the 3 years immediately preceding this application.
 - a. Clinical practice hours must include:
 - i. A minimum of 100 hours engaged in direct observation of a Senior/Approved Sexual Offender Treatment Provider conducting specialized sexual offender treatment; and
 - ii. A minimum of 100 hours engaged in co-facilitation of sexual offender treatment under the supervision of a Senior/Approved Sexual Offender Treatment Provider.
- 2. Of the 500 hour clinical practice and specialized training requirement:
 - a. A minimum of 60 hours or a maximum of 175 hours in sexual offender-specific specialized training;
 - i. No more than 16 training hours may be attributed to the treatment of sexual abuse victims.
 - b. May include clinical practice hours in juvenile sexual offender assessment and evaluation.

Examples:

Sexual offender treatment	225 hours
Specialized training	175 hours
Psychosexual evaluations	<u>100 hours</u>
Total:	500 hours

Or:

Sexual offender treatment	440 hours
Specialized training	<u>60 hours</u>
Total:	500 hours

PROFESSIONAL EXPERIENCE/SPECIALIZED TRAINING REQUIREMENT

Associate/Supervised Sexual Offender Treatment Provider, cont.

3. On another sheet, please provide the name(s), address(s) and telephone number(s) of the supervising agency and/or agency for which you worked. Describe your duties with the agency. Please also describe how the required hours were acquired and include substantiating documentation.

Do you have at least 60 hours of sexual offender-specific specialized training? Yes No

Do you have a minimum total of 500 hours of training and experience related to juvenile sexual offenders? Yes No

Do you have a minimum of 100 hours experience directly observing a Senior/Approved Sexual Offender Treatment Provider conducting specialized sexual offender treatment services? Yes No

Do you have a minimum of 100 hours experience co-facilitating sexual offender treatment services under the supervision of a Senior/Approved Sexual Offender Treatment Provider? Yes No

PROFESSIONAL INFORMATION

1. Please identify the types of sexual offenders with whom you have worked:

_____ Adult

_____ Extra-Familial

_____ Juvenile

_____ Violent Offenders

_____ Intra-Familial

_____ Low Functioning (IQ under 75)

_____ Female

_____ Other (explain) _____

2. Have you ever been denied membership in, or terminated from a professional organization?

Yes No (If yes, provide and attach a full explanation.)

3. Have you ever had a professional license, certification or registration revoked, suspended, or otherwise sanctioned; or have you ever surrendered such credential to avoid or in connection with action by such authority?

Yes No (If yes, provide and attach a full explanation.)

4. Are you currently being investigated for or pending resolution of an alleged ethical standards violation by a professional licensing board?

Yes No (If yes, provide and attach a full explanation.)

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect; or had prosecution or sentence deferred or suspended, in connection with:

Yes No The use or distribution of controlled substances?

Yes No Criminal sexual or violent behavior?

Yes No Any other crime, other than minor traffic infractions? (Including DUI and reckless driving.)

(If yes to any of the above, provide and attach a full explanation.)

ASSURANCES AND RELEASE

I acknowledge and agree to the following:

Read this entire application; answered all questions truthfully and completely; and to the best of my knowledge, the documentation provided in support of my application is accurate.

I have read and will comply with Idaho laws and rules, including the Idaho SOMB Standards and Guidelines for Practitioners, Evaluations and Treatment of Juvenile Sexual Offenders and agree to carry out the standards to the best of my ability related to the certification for which I am applying.

I give permission for the Idaho Sexual Offender Management Board (SOMB) to investigate my background as it relates to statements contained in this application for certification. I understand that intentionally false or misleading statements or intentional omissions may result in the denial or revocation of certification. I further understand that the SOMB may require additional information from me prior to making a determination regarding my application.

I understand that the information contained in my SOMB certification application file may be shared with SOMB staff or other authorized representatives.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, or federal), including professional licensing boards, to release upon the request of the SOMB or its authorized representatives any information files or records required by the SOMB in connection with processing this application. I understand that by signing this form I am authorizing the release of information about me that may otherwise be protected or confidential.

I further agree to hold the SOMB members and its staff or authorized representatives free from any civil liability for damages or complaints by reason of any action that is within the scope of the performance of their duties which they may take in connection with this application and/or the failure of the SOMB to issue certification.

Upon certification and as a condition of continued certification, I understand the SOMB members or its authorized representatives may contact or question, as necessary, any person, institution or organization during an investigation into any complaint made against me or as part of the quality assurance process.

Applicant Signature

Date

Please PRINT your name below exactly as you wish it to appear on your certificate.

PRINT

REFERENCES AND CONTACT INFORMATION

List the names, current addresses and phone numbers of (3) individuals who are familiar with your professional qualifications.

You are responsible for sending copies of the enclosed Letter of Reference form to the individuals you have listed below. They will be instructed to mail the completed forms directly to the SOMB.

1. Name:

Position/Organization:

Address:

Telephone Number:

2. Name:

Position/Organization:

Address:

Telephone Number:

3. Name:

Position/Organization:

Address:

Telephone Number:

Optional: List the names, current addresses and phone numbers of (3) individuals who are *not* listed as your references, but with whom you regularly work from any of: Idaho Dept. of Juvenile Corrections; Juvenile Probation; other law enforcement agency; or Health and Welfare.

1. Name:

Position:

Address:

Telephone Number:

2. Name:

Position:

Address:

Telephone Number:

3. Name:

Position:

Address:

Telephone Number:

LETTER OF REFERENCE FOR CERTIFIED SEXUAL OFFENDER TREATMENT PROVIDER APPLICANT – JUVENILE CLIENTS

(Applicant name) _____ has applied to be an Idaho Certified Sexual Offender Treatment Provider for juvenile clients.

The applicant has requested that you provide a statement regarding his/her professional and ethical qualifications. Your responses will not be shared with the applicant. Upon completion please mail or fax this letter of reference directly to the address/fax number listed below.

1. Your name and occupation: _____

2. You have known the applicant: professionally for _____ years; personally for _____ years.

3. How are you familiar with the applicant's work regarding clinical treatment of juvenile sexual offenders?

4. Do you believe the applicant demonstrates ethical integrity in professional and personal behavior?

Yes No (If No, please attach an explanation.)

5. To the best of your knowledge, has the applicant ever been accused, investigated, and/or involved in unprofessional, illegal or unethical conduct?

Yes No (If Yes, please attach an explanation.)

6. Please list the applicant's strengths and weaknesses regarding his/her work with adjudicated sexual offenders:

7. In your opinion, would you recommend this applicant for Sexual Offender Treatment Provider Certification?

I highly recommend

I recommend

I have reservations about recommending

I strongly do not recommend

(Please attach an explanation.)

I certify that to the best of my knowledge, the answers and statements provided above are true and complete.

Signature

Date

Telephone

Please return this reference to:

Sexual Offender Management Board
c/o Idaho Dept. of Correction
1299 N. Orchard St. Ste 110
Boise, ID 83706
FAX (208) 287-3322

REQUEST FOR CONDITIONAL WAIVER

Applicants may apply for a one time only conditional waiver only if they do not fully meet the professional experience qualifications and/or specialized training requirements.

Provisions:

1. Conditional waivers are limited to a period of two years, to afford the applicant time to attain the qualification requirements for the level of certification the applicant is seeking.
2. An applicant who is granted a conditional waiver may not represent himself/herself as a Certified Sexual Offender Treatment Provider.
 - a. An applicant who is granted a conditional waiver shall represent himself/herself as an **“Approved Senior (or Associate) Sexual Offender Treatment Provider by Waiver.”**
 - b. The sexual offender treatment provider roster published by the SOMB will identify a sexual offender treatment provider who is granted a conditional waiver, and will indicate the date the waiver expires.
3. The applicant must have a training plan to achieve full qualification requirements for the level of certification that the applicant is seeking.
4. Documentation must be included with the sexual offender treatment provider’s renewal application verifying his/her progress in attaining full qualification requirements for the level of certification the applicant is seeking.
5. If an applicant has not achieved the full qualification requirement for the level of certification originally sought during the two-year conditional waiver period, the waiver will be cancelled and the applicant will be placed in a less independent level of certification. Waivers will not be renewed.

I certify that I understand and agree to abide by the provisions for an approved sexual offender treatment provider conditional waiver.

Attached to this application is:

- A statement indicating why my request for conditional waiver should be considered; and
- A statement outlining my intended training plan to achieve full qualifications for the level of certification that I am seeking.

Applicant Signature

Date

ATTACHMENTS

Have you attached the following? **(As applicable for level of certification)**

- _____ Copy of current professional license (licensure in Idaho is not required to be certified as an Idaho Sexual Offender Treatment Provider, however, you must maintain a current license in a clinical practice field such as psychiatry, psychology, counseling or social work, etc. in your state of residence);
- _____ Documentation verifying current malpractice insurance;
- _____ Documentation qualifying professional experience;
- _____ Documentation verifying specialized education attendance;
- _____ Documentation related to your treatment program curriculum:
 - Program narrative describing your treatment theory/model
 - Treatment acceptance criteria
 - Templates of treatment plans, treatment contracts and agreements
 - Assessment tools utilized to inform treatment planning and to gauge treatment progress
 - Data collected to assess program impact and effectiveness
 - Program modality (e.g. individual, group, family, etc.)
 - Treatment program rules and expectations
 - Description of how treatment plans are developed and modified
 - Outline of modules, exercises and activities
- _____ Copies of the following documents that were developed on separate juvenile clients within the year preceding this application:
 - 2 redacted treatment plans
 - 2 redacted treatment summaries
 - 2 redacted treatment progress reports
- _____ Signed Assurances and Release form; and
- _____ Application processing fee – check or money order made payable to the Sexual Offender Management Board:
 - \$75 for Senior/Approved and Associate/Supervised certification levels;
 - \$50 for Provisional/Supervised certification level.

And if applicable,

- _____ Formal supervision agreement – applications for Associate and Provisional level providers will not be approved without pre-arranged supervision agreements;
- _____ Signed Application for Conditional Waiver form, with training plan outlining how you intend to meet applicable certification level requirements prior to certification renewal.

Please mail your application and attachments to:

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Attn: Accounts Receivable
Idaho Dept. of Correction
1299 N. Orchard St. Suite 110
Boise, ID 83706

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