



## **Application for Certified Peer Specialist (CPS) Training Program**

101 W. Third Street

Williamsport, PA 17701

Dates: March 4-8 & 18-22, 2019

9am-5pm

**Application Deadline: February 18, 2019**

**Cost: \$1375.00**

### **INFORMATION ABOUT THE TRAINING**

The Peer Specialist Certification Training is a ten day course. The curriculum focuses on education, skill building, and providing an experiential group process for training participants.

By participating in the training, participants will:

- Gain new knowledge and understanding of recovery, the peer support movement, trauma informed care, Wellness Recovery Action Plan (WRAP), Whole Health Action Management (WHAM);
- Develop new skills around engagement, outreach, ethics and boundaries, disclosure, documentation;
- Increase personal awareness;
- Enhance personal recovery.

Qualification for certification includes successfully completing a written test at the end of each week, full engagement in classroom discussions and participation in class activities. Attendance, punctuality and demonstrating recovery values are also part of the assessment for certification.

*In order to successfully complete the Certified Peer Specialist Training Program you will need to be present and participate on **all** of the scheduled days.*

Trainees will receive an additional certificate of completion for the Wellness Recovery Action Plan (WRAP<sup>®</sup>), which is covered during the training for two days. Full attendance on both days is required for certification.

Notification of training is based on having 14 participants identified to attend. If you are accepted into the training program you will be contacted by the Institute @ MHP to confirm your attendance.

*Learners who successfully complete the CPS Training Program meets the educational requirement for the PCB Grandparenting Process. More information about the Grandparenting Process can be found at: <https://www.pacertboard.org/cps>*

**WHO SHOULD ATTEND /CRITERIA**

The most recent Bulletin, OMHSAS-16-12 identifies the following criteria to be trained as CPS:

(a) Be self-identified individuals who have received or are receiving mental health services for a serious emotional disturbance or serious mental illness.

(b) Eighteen (18) years of age and older

(c) Have a high school diploma or general equivalency diploma and

(d) Within the last three (3) years, have either maintained at least 12 months of successful work or volunteer experience, or earned at least 24 credit hours at a college or post-secondary educational institution.

**Definitions:**

Serious Emotional Disturbance (SED) – A condition experienced by a person under 18 years of age who currently or at any time during the past year had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual; and that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.

Serious Mental Illness (SMI) - A condition experienced by persons 18 years of age and older who, at any time during the past year, had a diagnosable mental, behavioral, or emotional disorder that met the diagnostic criteria within the current DSM and that has resulted in functional impairment and which substantially interferes with or limits one or more major life activities. Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illness. Substance use disorders and developmental disorders are not included.

**I. CONTACT INFORMATION**

Full Name \_\_\_\_\_

Please print name as you wish it to appear on your Certificate(s) of Completion.

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number (cell) \_\_\_\_\_ Other Number \_\_\_\_\_

Email (strongly recommended) \_\_\_\_\_

**II. DEMOGRAPHIC AND IDENTIFICATION INFORMATION**

Date of birth \_\_\_\_\_

What is your race/ethnicity? *(Please check all that apply to you)*

- African American/Black
- Asian American/Pacific Islander/East Asian
- Caucasian/White
- Indigenous/American Indian
- Latino(a)/Hispanic
- Other racial/ethnicity descriptor \_\_\_\_\_
- Prefer Not to Answer

Gender Identification

- Female
- Male
- Transgender
- Gender-Non-Conforming
- Other gender descriptor \_\_\_\_\_
- Prefer Not to Answer

Do you have a valid Pennsylvania Driver's License? YES  NO

Have you served in the United States Armed Forces? YES  NO

If yes, dates served \_\_\_\_\_

Branch \_\_\_\_\_

Are you a family member of someone who has served or is currently serving in the United States Armed Forces? YES  NO

Have you received services from the Office of Vocational Rehabilitation within the past three years? YES  NO

Do you receive SSI and/or SSDI benefits?

YES  NO

**NOTE: The information requested in the next three sections are set by Office of Mental Health and Substance Abuse Services (OMHSAS) and are mandated criteria for certification as a Certified Peer Specialist.**

**III. EDUCATIONAL HISTORY**

Check all that apply and provide the years you attended (ex. 1995-1999):

- High School/GED Years Attended \_\_\_\_\_
- Associates Degree Years Attended \_\_\_\_\_
- Bachelor's Degree Years Attended \_\_\_\_\_
- Master's Degree or beyond Years Attended \_\_\_\_\_
- Other Education or Training Programs Years Attended \_\_\_\_\_

**IV. EMPLOYMENT HISTORY**

Please, list any work or volunteer experience that you have had in the past 3 years. If there is not enough space, please continue on the back of this sheet.

1. Where \_\_\_\_\_  
Date - From \_\_\_\_\_ to \_\_\_\_\_

Was it paid  or volunteer  (*check one*)

2. Where \_\_\_\_\_  
Date - From \_\_\_\_\_ to \_\_\_\_\_

Was it paid  or volunteer  (*check one*)

3. Where \_\_\_\_\_  
Date - From \_\_\_\_\_ to \_\_\_\_\_

Was it paid  or volunteer  (*check one*)

4. Where \_\_\_\_\_  
Date - From \_\_\_\_\_ to \_\_\_\_\_

Was it paid  or volunteer  (*check one*)

**V. MENTAL HEALTH CONSUMER HISTORY\*: Please select the response that reflects your lived experience.**

*\*Lived experience of Substance Use Treatment by itself is not sufficient to meet the requirement for CPS Training.*

I personally identify as someone who is a present or past recipient of mental health services for a serious mental illness or serious emotional disturbance.

OR

I personally identify as someone who is a present or past recipient of mental health services for a serious mental illness or serious emotional disturbance AND substance use abuse

**VI. Accommodations**

Are there any accommodations that you need in order to participate in the training? (i.e. seeing eye dog, note taker, sign language, interpreter, etc.)? Please describe.

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**VII. Emergency Contact Information**

Name \_\_\_\_\_  
Relationship to you \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Other Phone Number \_\_\_\_\_

**VIII. Short Essays: Please think about and answer the following questions. Each answer should be about 50 words.**

1. One key to recovery is the use of natural supports in your life. Please describe the definition and role natural supports play in your life?

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2. What makes a CPS unique and how does their role differ from other positions in Behavioral Health?
3. A key role for the CPS is to minimize stigma and be an ambassador for recovery. Describe a situation where you had to confront stigma.
4. Describe how working as a Certified Peer Specialist fits into your current life plans/goals?
5. What will be your greatest challenge in attending the CPS training from 9am-5pm for the entire ten (10) day period? What is your plan for addressing the challenge? Please be as specific as possible.

**IX. Full payment is required prior to training.** Please indicate how you will be paying for the Certified Peer Specialist training. An invoice will be sent once accepted into the training. Institute@MHP may share information with sponsoring agencies/organizations/entities.

**Self:** Invoice will be mailed to mailing address listed on application.

**Office of Vocational Rehabilitation (OVR)**

Send invoice to:

OVR District \_\_\_\_\_  
OVR Contact Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_

**Sponsoring Agency or Company**

Send invoice to:

Name of Agency/Company \_\_\_\_\_  
Agency Contact Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_

**Other**

Send invoice to:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone/Email \_\_\_\_\_

**X. TRAINING APPLICANT SIGNATURE**

By signing this application, I am confirming that I understand, meet and agree to all of the criteria to participate in this training program. Responses to all questions on the application are my own. In addition, I fully intend to be present and an active participant in the Certified Peer Specialist Training Program for the entire program, including the mandatory orientation session and all 10 days of training. I am aware of the following important dates:

- **Application Deadline:** February 18, 2019
- **Welcome Letter to Accepted Participants:** February 22, 2019

Finally, I understand that The Institute@MHP may share information with sponsoring agencies/organizations/entities.

Applicant Signature: \_\_\_\_\_

*Thank you for your application.*

**Please submit your completed application via fax or email February 18, 2019**

Attn: Administrative Assistant

Fax: 215-636-6328

Email (Preferred Method): [recovery@mhphope.org](mailto:recovery@mhphope.org)

If you have any questions please contact:

Administrative Assistant, Institute for Recovery

Phone: 267-507-3888

**Please include the following to ensure timely processing of your application:**

- Completed Application (REQUIRED):** Fully answer every question asked on this application.
- Contact Information for OVR or Other Funding Source (REQUIRED):** Kindly remember to completely fill out section IX with information about the contact for the funding of this training. An invoice will be sent once accepted into the training.
- Signature (REQUIRED):** Remember to sign the application in section X.
- Recommendation Letter (REQUIRED):** Please submit recommendation letter with your application. The letter of recommendation should be from someone who knows your potential as a peer supporter. Ask the person to indicate their relationship to you and how they know you in the letter. Recommendation letters may be written by former or present employers, teachers, volunteer supervisors, clergy, or staff who has provided services or treatment with you.

**Cancellation/refund policy:**

Refund requests received 30 days or more prior to the course start date will be honored. Refund requests made less than 30 days prior to the course start date will incur a \$50 processing fee. No refunds will be made on or after the course start date.