Mississippi Department of Mental Health (DMH)
Division of Professional Licensure and Certification (PLACE)

DMH PLACE Professional Credentialing

DMH Community Support Specialist Application Forms PCCSS & CCSS

Effective Date – June 30, 2017

CONTACT INFORMATION

Mississippi Department of Mental Health (DMH)
Bureau of Outreach, Planning and Development (OPD)
Division of Professional Licensure and Certification (PLACE)
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201
601-359-1288
place@dmh.ms.gov

IMPORTANT NOTICE:

Only individuals who are currently employed in Mississippi's "state mental health system," as defined in the most current version of the *DMH PLACE Professional Credentialing Rules and Requirements* document are eligible to apply for a DMH professional credential. This document is located on the "PLACE" page of the DMH website: www.dmh.ms.gov. Please review credentialing requirements in this document before submitting an application.

Provisionally Certified Community Support Specialist (PCCSS)
Application Directions, Checklist & Forms

The information below includes:

- Overview of PCCSS Requirements;
- PCCSS General Application Directions;
- PCCSS Application Checklist; and,
- PCCSS Application Forms.

Before submitting an application, be sure to review the complete description of PCCSS requirements and the complete application process for PCCSS located in the most current version of the *DMH PLACE Professional Credentialing Rules and Requirements* document, hereafter referred to as the *Rules and Requirements* document. This document is located on the "PLACE" page of the DMH website: www.dmh.ms.gov.

PCCSS - General Requirements Overview

Requirements to apply for PCCSS	Description
Employment	• Must be currently employed in Mississippi's "state mental health system," as defined in the *Rules and Requirements* document • If you are not sure you meet this requirement, please check with your Personnel Office. • Initial applicants must have responsibility for providing (or supervising the provision of) community support, Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver support coordination services, IDD targeted case management services or wraparound facilitation services. Upgrade applicants are exempt from this specific employment requirement.
Education	• Refer to the DMH Community Support Specialist Education Requirement outlined in the *Rules and Requirements* document • If you are not sure you meet this requirement, please contact the DMH Division of PLACE and/or consult with your program Staff Development Officer (SDO).
Ethics	• All applicants must read and abide by the "DMH Principles of Ethical and Professional Conduct" located in the *Rules and Requirements* document. It is the applicant's responsibility to read these principles before signing and submitting the application. (Applicants should also review the corresponding "Grounds for Disciplinary Action.") • Applicants must inform the Division of PLACE of any previous or pending disciplinary action against them by any professional credentialing body or association.
Criminal Background Checks	• As part of the application process, the Division of PLACE ensures that employers have conducted background checks on individuals applying for DMH professional credentials. No one will be credentialed without proof of background checks.
Experience	• NONE - No experience is required to apply for Provisionally Certified Community Support Specialist (PCCSS). • Experience is required to apply for full certification – DMH Certified Community Support Specialist (CCSS).

PCCSS – General Application Directions

General Application Directions

- Applicants should read all directions and application materials before beginning the application process. **Each application form has specific directions which must be followed.**

- Certain application forms must bear original signatures, as indicated on the form. Copies or faxes are not accepted.

- Be sure to provide all information requested. Every blank should have a response, even if it is "Not Applicable."

- With the exception of the official transcript, **all application materials must be submitted together in one application packet.** The official transcript can either be included in the application packet or sent to the DMH Division of PLACE directly from the college/university. This is the only application piece which may be submitted separately.

- The official transcript must be submitted in a sealed college/university envelope and document that the educational requirement has been met. If sent to you, **do not open it** before placing it in your application packet. If, however, the applicant chooses to submit his/her official transcript(s) in an electronic format, it is the applicant's responsibility to have the college/university submit, along with the electronic transcript, sufficient documentation to verify that the electronic transcript is an official copy; accordingly, such documentation will be subject to Division of PLACE/PLACE Review Board approval.

- If you currently hold another DMH professional credential, and the DMH Division of PLACE already has the necessary official copy of your transcript on file, you should designate this information in the appropriate space on the Application Form. If this is the case, submitting another official transcript is not necessary.

- All submission deadlines reflect the date received by the DMH Division of PLACE, not postmarked dates.

- The PLACE Review Board only considers complete applications; all application deficiencies must be resolved.

- Only forms prescribed by the DMH Division of PLACE may be utilized to apply for certification. Application forms may be changed without prior notice. The most current version should be utilized.

- Once submitted, all application materials become the property of DMH. Application materials will not be returned; the applicant should keep a copy of the application materials, except those under seal.

- All fees pertaining to DMH professional credentialing are nonrefundable and nontransferable. If an application or other credentialing fee is submitted in error, it will not be refunded.

- **The PCCSS Application Fee is $30.00**. Fees must be paid in full by **check or money order** made payable to the Mississippi Department of Mental Health. **Cash is not accepted.**

- No application is considered complete without the required fees.

- Processing of an application will cease upon return of a check due to insufficient funds.

PCCSS – Application Packet Checklist

To apply for **temporary certification as a PCCSS**, an individual should submit an **application packet** which contains the following materials; **utilize this checklist to ensure that you have included all required application materials:**

☐ **PCCSS Application Form – Pages 5, 6 and 7**

- Must be signed by the Applicant in **BLUE INK** and dated

☐ **PCCSS Verification of Employment Form – Page 8**

- Must be completed by the Personnel Office at the applicant's current place of employment and placed in a signed/sealed envelope, according to the directions on the form
- Must show proof of current employment in Mississippi's "State Mental Health System"
- Must show designation of applicant having responsibility for providing (or supervising the provision of) community support, Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver support coordination services, IDD targeted case management services or wraparound facilitation services (or appropriate explanation)
- Must show proof that Criminal Background Checks have been conducted

☐ **Official Transcript**

- Include an official copy of your transcript(s) in your application packet **OR**
- Have the college or university submit the official transcript(s) directly to the DMH Division of PLACE **OR**
- Designate on your Application Form that the DMH Division of PLACE already has your official transcript(s) on file

☐ **Application Fee – $30.00**

- Payable by check or money order to the "Mississippi Department of Mental Health"
- **Cash is not accepted.**
- Application fees are nonrefundable and nontransferable.

Mail your complete application packet to:

Mississippi Department of Mental Health
Division of Professional Licensure and Certification (PLACE)
239 North Lamar Street
1101 Robert E. Lee Building
Jackson, MS 39201

APPLICATION FORM for
Provisionally Certified Community Support Specialist (PCCSS)

ATTENTION: *(This is the Application Form for* ***PROVISIONAL*** *Certification.)*

Directions: This form is to be completed by the Applicant. Fill in every blank (even if the response is "Not Applicable" and/or check the appropriate boxes. The application MUST BE signed by the Applicant in BLUE INK and dated.

Personal Information

1. a. Name: ❑Mr. ❑Ms. ❑Dr. _____
(Type or Print name EXACTLY as it should appear on the certificate.)

b. Name(s) used on Transcripts/Records if different from above: _____

_____

2. Social Security Number: _____-_____-_____ 3. Gender: ❑Male ❑Female
This is the only place your complete SSN is required. Everywhere else, indicate only the last four digits of your SSN.

4. Date of Birth: _____/_____/_____

5.

Mailing Address	Street Address or P.O. Box:		
City, State, Zip	City:	State:	Zip:
County of Residence			
Home /Cell Telephone Numbers	Home Number:	Cell Number:	
Email Address **(REQUIRED)**			

The Division of PLACE will need to correspond with you regarding your application materials and/or related matters; **a functional email address is mandatory.**

Employment Information

6.

CURRENT Place of Employment			
Place of Employment (Physical) **Street Address**			
City, State, Zip	City:	State:	Zip:
Office Telephone Number			

Applicant's Name_____ **SSN: XXX-XX-**_____
(Please type or print) **(Last 4 Digits)**

DMH Professional Credentialing History/Information

7.

Do you currently hold (or have you ever held) any **Mississippi Department of Mental Health (DMH)** professional credential?	❑ YES ❑ NO	
If "yes," please list the type(s) of **Mississippi Department of Mental Health (DMH)** Professional Credential(s) held, along with the credential expiration date(s) (if known)	**Credential Type(s)**	**Expiration Date(s)**

Additional Professional Credentialing History/Information

8.

Have you ever had any disciplinary action taken against you by DMH OR **any other professional credentialing body/association** OR do you presently have any pending disciplinary action?	❑ YES ❑ NO
If "yes," the following items must be completed: the name of the credential; the name of the credentialing body; and, a brief explanation of the previous or pending action.	Credential Name:
	Credentialing Body:
	Brief explanation of previous/pending action (use reverse side or attachment if needed):

Educational/Official Transcript Information

9.

List all earned Degree(s) Title(s) & Major(s) *(for example B.S. in Psychology)*	
Date Degree(s) listed above was Awarded/Conferred (Month/Year)	
List the name(s) of ALL College/Universities from which you are submitting official transcripts to show education requirement is met.	
My official transcript(s) is/are included in this application packet.	❑ YES ❑ NO
My official transcript(s) is/are being mailed/emailed directly to PLACE by the educational institution.	❑ YES ❑ NO
PLACE already has an official copy of my transcript(s) on file.	❑ YES ❑ NO

Applicant's Name_____ **SSN: XXX-XX-**_____
(Please type or print) **(Last 4 Digits)**

Experience Assurance

I, the Applicant, acknowledge that no relevant work experience is required to apply for provisional certification. I also acknowledge that I must have a minimum of one year (12 months or its full-time equivalent) of full-time work experience in the area of community support, ID/DD Waiver Support Coordination, IDD Targeted Case Management, and/or Wraparound Facilitation, which is accrued at a Mississippi "state mental health system" program and is verified and supervised by a Qualified Supervisor, as outlined in the current *DMH PLACE Professional Credentialing Rules and Requirements* document in order to upgrade to full certification (CCSS). I further acknowledge that this experience must have been accrued by the end of my Provisional Certification Period. **My signature in the Applicant Signature section below acknowledges this understanding.**

-APPLICANT MUST SIGN & DATE BELOW-

Directions: Read the "Applicant's Statements of Assurance" below. If you agree with the "Applicant's Statements of Assurance," print/type your full name and last four digits of your SSN in the designated space below, then **sign below in BLUE INK and date the form**. *Failure to agree with these terms will delay and/or prohibit processing your application.*

-Applicant's Statements of Assurance-

I agree that I am the person who completed this application; that I am currently employed in the "state mental health system," as described in the current **DMH PLACE Professional Credentialing Rules and Requirements* document; that the statements contained herein are true in every respect; **that I have read the current ****DMH PLACE Professional Credentialing Rules and Requirements*** **document and the "DMH Principles of Ethical and Professional Conduct" (and corresponding "Grounds for Disciplinary Action") and will abide by these *Rules and Requirements* and "Principles";** that DMH (and its representatives) has the right to contact any person/organization in reviewing this application and/or in maintenance of certification; that he/she authorizes the release of any information requested by DMH (and its representatives) in reviewing this application and/or in maintenance of certification; that I understand that upon certification, certain certification data are considered public information; that I release DMH (and its representatives) from all liability and claims arising from any services rendered by the undersigned; that I have read and understood these "Applicant's Statements of Assurance"; that I understand that all application materials become the property of DMH and will not be returned; and, that I understand that the application fee is nonrefundable/nontransferable. *(The current *DMH PLACE Professional Credentialing Rules and Requirements* document is available online at the DMH website: www.dmh.ms.gov.)

Applicant's Printed/Typed Name: _____ **SSN:** XXX-XX-_____
(Last 4 Digits)

Signature of Applicant _____
(Signature in Blue Ink)

Date: _____

VERIFICATION OF EMPLOYMENT FORM (PCCSS)

*Attention: (This is the Verification of Employment Form for **PROVISIONAL** certification.)*

Directions: This form is to be completed by the Personnel Officer at the Applicant's current place of employment. Please type or print ALL INFORMATION; fill in every blank or check the appropriate boxes. Upon completion, **the Personnel Officer should seal the form in an envelope and sign his/her name across the envelope's seal.** The signature on the envelope should match the signature on the enclosed form. The Personnel Officer should then **return the sealed envelope to the Applicant** for submission.

1. **Employment:**

Applicant/Employee's Name & SSN	Applicant/Employee Name:
	Social Security Number: XXX-XX-_____ **(Last 4 Digits)**
Applicant/Employee's Current Place of Employment & Place of Employment (Physical) Street Address	Overall Agency/Organization/Program Name:
	Place of Employment (Physical) **Street Address (Information must be included):**
Applicant/Employee's Date of Hire (Only Report a Single Date of Hire) **OR** (if applicable) **Applicant/Employee's Date of Transfer -** (Refer to the *Rules and Requirements* document for instruction on reporting Date of Hire vs. Date of Transfer)	_____/_____/_____ **Month Day Year**
Applicant/Employee's Job Title	
Does the applicant/employee have responsibility for providing or supervising the provision of community support, ID/DD Waiver support coordination services, IDD targeted case management services or wraparound facilitation services?	❑ YES ❑ NO (Provide explanation) Explanation:

2. **Background Check: (No one will be credentialed without proof of criminal background checks.)**
   As appropriate to the Applicant's position and professional responsibilities, have background checks been conducted regarding this Applicant? ❑ YES ❑ NO (Provide explanation)

   Explanation: _____

3. **State Mental Health System Qualification: (Check the appropriate qualification).**
   a. This applicant/employee **currently** works for an agency/organization which is **certified and/or funded** by the Mississippi Department of Mental Health. ❑ YES ❑ NO (Provide explanation)

      Explanation: _____

   b. This applicant/employee **currently** works for a program which is **operated/administered** by the Mississippi Department of Mental Health. ❑ YES ❑ NO (Provide explanation)

      Explanation: _____

4. Personnel Officer's Name: _____ Email: _____

_____ _____

Signature of Personnel Officer **Date Form Completed**

Certified Community Support Specialist (CCSS)
Application Directions, Checklist & Forms

The information below includes:

- Overview of CCSS Requirements;
- CCSS General Application Directions;
- CCSS Application Checklist; and,
- CCSS Application Forms.

Before submitting an application, be sure to review the complete description of CCSS requirements and the complete application process for CCSS located in the most current version of the *DMH PLACE Professional Credentialing Rules and Requirements* document, hereafter referred to as the *Rules and Requirements* document. This document is located on the "PLACE" page of the DMH website: www.dmh.ms.gov.

CCSS - General Requirements Overview

Requirements to apply for CCSS	Description
Employment	• Must be currently employed in Mississippi's "state mental health system," as defined in the *Rules and Requirements* document • If you are not sure you meet this requirement, please check with your Personnel Office. • **Initial applicants** (those applying directly for CCSS) must have responsibility for providing (or supervising the provision of) community support, Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver support coordination services, IDD targeted case management services or wraparound facilitation services. Upgrade applicants are exempt from this specific employment requirement.
Education	• Refer to the DMH Community Support Specialist Education Requirement outlined in the *Rules and Requirements* document • If you are not sure you meet this requirement, please contact the DMH Division of PLACE and/or consult with your program Staff Development Officer (SDO).
Ethics	• All applicants must read and abide by the "DMH Principles of Ethical and Professional Conduct" located in the *Rules and Requirements* document. It is the applicant's responsibility to read these principles before signing and submitting the application. (Applicants should also review the corresponding "Grounds for Disciplinary Action.") • Applicants must inform the Division of PLACE of any previous or pending disciplinary action against them by any professional credentialing body or association.
Criminal Background Checks	• As part of the application process, the Division of PLACE ensures that employers have conducted background checks on individuals applying for DMH professional credentials. No one will be credentialed without proof of background checks.
Experience	• A minimum of one year of full-time work experience in the area of community support, ID/DD Waiver Support Coordination, IDD Targeted Case Management, and/or Wraparound Facilitation, which is accrued at a Mississippi "state mental health system" program and is verified and supervised by a qualified supervisor; this experience may either be the provision or supervision of community support, ID/DD Waiver Support Coordination, IDD Targeted Case Management, and/or Wraparound Facilitation services • Refer to the *Rules and Requirements* document for additional information.
Exam/Training	• Refer to the *Rules and Requirements* document for detailed information regarding the Exam/Training Requirement.

General Application Directions

- Applicants should read all directions and application materials before beginning the application process. **Each application form has specific directions which must be followed.**

- Certain application forms must bear original signatures, as indicated on the form. Copies or faxes are not accepted.

- Be sure to provide all information requested. Every blank should have a response, even if it is "Not Applicable."

- With the exception of the official transcript, **all application materials must be submitted together in one application packet.** The official transcript can either be included in the application packet or sent to the DMH Division of PLACE directly from the college/university. This is the only application piece which may be submitted separately.

- The official transcript must be submitted in a sealed college/university envelope and document that the educational requirement has been met. If sent to you, **do not open it** before placing it in your application packet. If, however, the applicant chooses to submit his/her official transcript(s) in an electronic format, it is the applicant's responsibility to have the college/university submit, along with the electronic transcript, sufficient documentation to verify that the electronic transcript is an official copy; accordingly, such documentation will be subject to Division of PLACE/PLACE Review Board approval.

- If you currently hold another DMH professional credential, and the DMH Division of PLACE already has the necessary official copy of your transcript on file, you should designate this information in the appropriate space on the Application Form. If this is the case, submitting another official transcript is not necessary.

- All submission deadlines reflect the date received by the DMH Division of PLACE, not postmarked dates.

- The PLACE Review Board only considers complete applications; all application deficiencies must be resolved.

- Only forms prescribed by the DMH Division of PLACE may be utilized to apply for certification. Application forms may be changed without prior notice. The most current version should be utilized.

- Once submitted, all application materials become the property of DMH. Application materials will not be returned; the applicant should keep a copy of the application materials, except those under seal.

- All fees pertaining to DMH professional credentialing are nonrefundable and nontransferable. If an application or other credentialing fee is submitted in error, it will not be refunded.

- **Individuals who paid the application fee when applying for PCCSS DO NOT PAY this fee again when applying to UPGRADE to CCSS. However, individuals applying directly for CCSS (thus skipping PCCSS) must pay this one-time fee.** Refer to the *Rules and Requirements* document for additional information.

- No application is considered complete without the required fees.

- Processing of an application will cease upon return of a check due to insufficient funds.

CCSS – Application Packet Checklist

Before submitting your complete CCSS application packet (initial application OR upgrade application), utilize this checklist to ensure that you have included all required application materials:

The **CCSS application packet (initial or upgrade), at a minimum**, must contain the following:

☐ **CCSS Application Form – Pages 13, 14 and 15**

- Must be signed by the Applicant in **BLUE INK** and dated

☐ **CCSS Verification of Employment Form – Page 16**

- Must be completed by the Personnel Office at the applicant's current place of employment and placed in a signed/sealed envelope, according to the directions on the form
- Must show proof of current employment in Mississippi's "State Mental Health System"
- **Initial applicants** (those applying directly for CCSS) - Must show designation of applicant having responsibility for providing (or supervising the provision of) community support, Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver support coordination services, IDD targeted case management services or wraparound facilitation services (or appropriate explanation)
- Must show proof that Criminal Background Checks have been conducted

☐ **CCSS Verification of Work Experience Form – Pages 17 and 18**

- Must be completed by a "Qualified Supervisor" – refer to the *Rules and Requirements* document for "Qualified Supervisor" information
- Must be placed in a **signed/sealed envelope** (by the supervisor), according to the form's directions, and returned to the Applicant for inclusion with the CCSS application packet

☐ **Web-based Training Record (Exam/Training Requirement):** A CCSS applicant must include a **signed** copy **(in blue ink)** of his/her web-based training learner transcript in the CCSS application packet.

- The learner transcript, containing the CCSS applicant's original signature, must be signed in **blue** ink, attesting to the fact that the entire web-based training component was completed by the applicant.
- The submitted learner transcript must contain the course names and corresponding dates of completion for each course in the web-based training component and the total number of course hours completed.
- **Submission of this information is the applicant's responsibility.**

If the CCSS applicant is submitting an initial (not upgrade) application, the following additional CCSS application components **are also required**:

☐ **Official Transcript**

- **If UPGRADING from PCCSS**, no additional transcript is required.

- **IF applying DIRECTLY for CCSS** (**not upgrade**):

- Include an official copy of your transcript(s) in your application packet **OR**
- Have the college or university submit the official transcript(s) directly to the Division of PLACE **OR**
- Designate on your Application Form that the Division of PLACE already has your official transcript(s) on file

☐ **Application Fee (IF applying directly for CCSS, not upgrade from PCCSS) - $30.00**

- **If upgrading from PCCSS**, no application fee is required.

  - Individuals who paid the application fee when applying for PCCSS **DO NOT PAY** this fee again.
  - DO NOT pay the application fee twice; application fees are nonrefundable and nontransferable.

- **IF applying directly for CCSS (thus skipping PCCSS)**, you must pay the application fee.

  - Payable by check or money order to the "Mississippi Department of Mental Health"
  - **Cash is not accepted.**
  - Application fees are nonrefundable and nontransferable.

Mail your complete application packet to:

Mississippi Department of Mental Health
Division of Professional Licensure and Certification (PLACE)
239 North Lamar Street
1101 Robert E. Lee Building
Jackson, MS 39201

APPLICATION FORM for
Certified Community Support Specialist (CCSS)

ATTENTION: *(This is the Application Form for **FULL** Certification.)*

Directions: This form is to be completed by the Applicant. Fill in every blank (even if the response is "Not Applicable" and/or check the appropriate boxes. The application MUST BE signed by the Applicant in BLUE INK and dated.

Check the appropriate box:

❑ **Initial** Application - (Applicant is applying directly for full certification.)

OR

❑ **Upgrade** Application - (Applicant is applying to upgrade from provisional to full certification.)

Personal Information

1. a. Name: ❑Mr. ❑Ms. ❑Dr. _____

(Type or Print name EXACTLY as it should appear on the certificate.)

b. Name(s) used on Transcripts/Records if different from above: _____

_____

2. Social Security Number: _____-_____-_____ 3. Gender: ❑Male ❑Female

(This is the only place your complete SSN is required. Everywhere else, indicate only the last four digits of your SSN.)

4. Date of Birth: _____/_____/_____

5.

Mailing Address	Street Address or P.O. Box:		
City, State, Zip	City:	State:	Zip:
County of Residence			
Home /Cell Telephone Numbers	Home Number:	Cell Number:	
Email Address **(REQUIRED)**			

The Division of PLACE will need to correspond with you regarding your application materials and/or related matters; **a functional email address is mandatory**.

Employment Information

6.

CURRENT Place of Employment			
Place of Employment (Physical) **Street Address**	Street Address:		
City, State, Zip	City:	State:	Zip:
Office Telephone Number			

Applicant's Printed Name_____ **SSN: XXX-XX-**_____
(Please type or print) **(Last 4 Digits)**

DMH Professional Credentialing History/Information

7.

Do you currently hold (or have you ever held) any **Mississippi Department of Mental Health (DMH)** professional credential?	❑ YES ❑ NO	
If "yes," please list the type(s) of **Mississippi Department of Mental Health (DMH)** Professional Credential(s) held, along with the credential expiration date(s) (if known)	**Credential Type(s)**	**Expiration Date(s)**

Additional Professional Credentialing History/Information

8.

Have you ever had any disciplinary action taken against you by DMH OR **any other professional credentialing body/association** OR do you presently have any pending disciplinary action?	❑ YES ❑ NO
If "yes," the following items must be completed: the name of the credential; the name of the credentialing body; and, a brief explanation of the previous or pending action.	Credential Name:
	Credentialing Body:
	Brief explanation of previous/pending action (use reverse side or attachment if needed):

Educational/Official Transcript Information

Directions FOR THIS SECTION ONLY:
If this is an **INITIAL APPLICATION, you MUST Complete** the Educational/Transcript Information below.
If this is an **UPGRADE APPLICATION**, **you MAY Omit** the Educational/Transcript Information below.

9.

List all earned Degree(s) Title(s) & Major(s) *(for example B.S. in Psychology)*		
Date Degree(s) listed above was Awarded/Conferred (Month/Year)		
List the name(s) of ALL College/Universities from which you are submitting official transcripts to show education requirement is met.		
My official transcript(s) is/are included in this application packet.	❑ YES	❑ NO
My official transcript(s) is/are being mailed/emailed directly to PLACE by the educational institution.	❑ YES	❑ NO
PLACE already has an official copy of my transcript(s) on file.	❑ YES	❑ NO

Applicant's Printed Name_____ **SSN: XXX-XX-**_____
(Please type or print) **(Last 4 Digits)**

Required Work Experience

A minimum of one year (12 months or its full-time equivalent) of full-time work experience in the area of community support, ID/DD Waiver Support Coordination, IDD Targeted Case Management, and/or Wraparound Facilitation, which is accrued at a Mississippi "state mental health system" program and is verified and supervised by a Qualified Supervisor, as outlined in the current *DMH PLACE Professional Credentialing Rules and Requirements* document, is required. **I have included Verification of Work Experience Form(s) from the following supervisor(s):**

10. **List the name(s) of each Supervisor who completed a Verification of Work Experience Form(s) for you.** You may submit more than one Verification of Work Experience Form, if needed; list each supervisor's name separately.	**Supervisor's Name(s):**

Exam/Training Component

11. **DMH Community Support Specialist program web-based exam/training component**	I have completed the DMH Community Support Specialist program web-based exam/training component, and a signed copy of my web-based training record is included. *(check one option below):* ❑ Yes ❑ No

-APPLICANT MUST SIGN & DATE BELOW-

Directions: Read the "Applicant's Statements of Assurance" below. If you agree with the "Applicant's Statements of Assurance," print/type your full name and last four digits of your SSN in the designated space below, then **sign below in BLUE INK and date the form**. *Failure to agree with these terms will delay and/or prohibit processing your application.*

-Applicant's Statements of Assurance-

I agree that I am the person who completed this application; that I am currently employed in the "state mental health system," as described in the current **DMH PLACE Professional Credentialing Rules and Requirements* document; that the statements contained herein are true in every respect; **that I have read the current ***DMH PLACE Professional Credentialing Rules and Requirements* **document and the "DMH Principles of Ethical and Professional Conduct" (and corresponding "Grounds for Disciplinary Action") and will abide by these *Rules and Requirements* and "Principles";** that DMH (and its representatives) has the right to contact any person/organization in reviewing this application and/or in maintenance of certification; that he/she authorizes the release of any information requested by DMH (and its representatives) in reviewing this application and/or in maintenance of certification; that I understand that upon certification, certain certification data are considered public information; that I release DMH (and its representatives) from all liability and claims arising from any services rendered by the undersigned; that I have read and understood these "Applicant's Statements of Assurance"; that I understand that all application materials become the property of DMH and will not be returned; and, that I understand that the application fee is nonrefundable/nontransferable. *(The current *DMH PLACE Professional Credentialing Rules and Requirements* document is available online at the DMH website: www.dmh.ms.gov.)

Applicant's Printed/Typed Name: _____ **SSN:** XXX-XX-_____
(Last 4 Digits)

Signature of Applicant _____
*** (Signature in Blue Ink)**

Date: _____

VERIFICATION OF EMPLOYMENT FORM (CCSS)

*Attention: (This is the Verification of Employment Form for **FULL** certification.)*

Directions: This form is to be completed by the Personnel Officer at the Applicant's current place of employment. Please type or print ALL INFORMATION; fill in every blank or check the appropriate boxes. Upon completion, **the Personnel Officer should seal the form in an envelope and sign his/her name across the envelope's seal.** The signature on the envelope should match the signature on the enclosed form. The Personnel Officer should then **return the sealed envelope to the Applicant** for submission.

1. **Employment:**

Applicant/Employee's Name & SSN	Applicant/Employee Name:
	Social Security Number: XXX-XX-_____ **(Last 4 Digits)**
Applicant/Employee's Current Place of Employment & Place of Employment (Physical) Street Address	Overall Agency/Organization/Program Name:
	Place of Employment (Physical) **Street Address** **(Information must be included):**
Applicant/Employee's Date of Hire (Only Report a Single Date of Hire) **OR** (if applicable) **Applicant/Employee's Date of Transfer -** (Refer to the *Rules and Requirements* document for instruction on reporting Date of Hire vs. Date of Transfer)	_____/_____/_____ **Month Day Year**
Applicant/Employee's Job Title	
Does the applicant/employee have responsibility for providing or supervising the provision of community support, ID/DD Waiver support coordination services, IDD targeted case management services or wraparound facilitation services?	❑YES ❑NO (Provide explanation) Explanation:
	This form is part of the applicant/employee's CCSS **upgrade** application. ❑YES ❑NO ❑Unknown

2. **Background Check: (No one will be credentialed without proof of criminal background checks.)**
   As appropriate to the Applicant's position and professional responsibilities, have background checks been conducted regarding this Applicant? ❑YES ❑NO (Provide explanation)
   Explanation: _____

3. **State Mental Health System Qualification: (Check the appropriate qualification).**
   a. This applicant/employee **currently** works for an agency/organization which is **certified and/or funded** by the Mississippi Department of Mental Health. ❑YES ❑NO (Provide explanation)

      Explanation: _____

   b. This applicant/employee **currently** works for a program which is **operated/administered** by the Mississippi Department of Mental Health. ❑YES ❑NO (Provide explanation)

      Explanation: _____

4. Personnel Officer's Name: _____ Email: _____

_____ _____

Signature of Personnel Officer **Date Form Completed**

VERIFICATION OF WORK EXPERIENCE FORM for
Certified Community Support Specialist (CCSS)

GENERAL DIRECTIONS: Please type or print clearly ALL INFORMATION; fill in every blank and/or check the appropriate boxes. Specific Applicant and Supervisor instructions are listed below.

PART ONE – APPLICANT

Applicant's Name: _____ Social Security Number: XXX-XX-_____
(Last 4 Digits)

Applicant Instructions:

- Complete your name and SSN above.
- Submit this form **(pages 17 and 18)** to your supervisor.
- If you have more than one supervisor under whom you completed your required work experience, submit a separate form for each supervisor.
- Once the form is completed by your supervisor, retrieve the form in a **signed/sealed** envelope from your supervisor and include in your application packet. **Do NOT open the sealed envelope.**

PART TWO- SUPERVISOR

Supervisor Instructions:

- Verify that you meet the supervisor qualifications to complete and sign this form; otherwise, return this form to the applicant.
- **Complete ALL information below.** If you make an error, mark through it, write the correction above or beside the error and initial.
- **Sign and date this form**. Enclose the form **(pages 17 and 18)** in a sealed envelope; sign your name over the envelope's seal. **The form will not be accepted unless it is submitted in a signed/sealed envelope with the signature on the form matching the signature on the seal.**
- This information will be kept confidential by the Division, although the Applicant may be informed as to whether the evaluation is generally favorable or unfavorable.
- **Return the completed form in a signed/sealed envelope to the applicant.**

1. SUPERVISOR'S Current Information:

Supervisor's Name/Job Title	**Supervisor** Name:		
	Supervisor Job Title:		
Supervisor's Place of Employment	Overall Agency/Organization/Program Name:		
Business (Physical) Street Address			
City, State, Zip	City:	State:	Zip:
Business Contact Information	Phone:	Email:	
Supervisor's Qualification **(Check One)**	❑ State Mental Health System Program's designated Director of Community Support Services ❑ State Mental Health System Program's designated Director of ID/DD Waiver Support Coordination ■ State Mental Health System Program's designated IDD Targeted Case Management Supervisor ❑ State Mental Health System Program's designated Wraparound Facilitation Supervisor ❑ State Mental Health System Program's current Executive Director (i.e., top-level administrator)		

2. APPLICANT'S Information & Work Experience under the Supervisor:

Applicant's Name & Last 4 Digits of Applicant's SSN	Applicant Name:	Applicant SSN: XXX-XX-_____
Dates When You Supervised the Applicant's Work Experience **(Do not use "Current")**	From _____/_____ to _____/_____ (Month/Year) (Month/Year)	
In what capacity have you supervised the Applicant? **(Check One)**	❑ Director of Community Support Services ❑ Director of ID/DD Waiver Support Coordination ❑ IDD Targeted Case Management Supervisor ❑ Wraparound Facilitation Supervisor ❑ Organization's Executive Director ❑ Other: _____	
Overall Agency/Organization **where you supervised the Applicant's Work Experience**	❑ Same as "Supervisor's Place of Employment" Listed in Item #1 on previous page **OR** ❑ Different from "Supervisor's Place of Employment" Listed in Item #1 on previous page; **List Overall Agency/Organization Name/Address Here**:	
Applicant's Job Title at the time of supervision	Applicant's Job Title:	
At the time of supervision, the Applicant was: **(Check only one)**	❑ A full-time employee (40 hours/week) ❑ A part-time employee at _____% **(percentage must be included)**	
Did the Applicant's duties include either the provision OR supervision of community support services, ID/DD Waiver support coordination services, IDD targeted case management services or wraparound facilitation services?	❑ YES ❑ NO (Provide explanation) Explanation:	
Describe the professional duties the Applicant performed under your supervision. **(Add an attachment if needed.)**		

3. Supervisor Recommendation

Check ONLY ONE of the following statements; attach an explanation if you select the second or third option.

❑ **I recommend**, without reservation, that the Applicant be considered for certification.

❑ As described in the attached explanation, **I recommend with some reservations**, that the Applicant be considered for certification. ❑ Explanation Attached

❑ As described in the attached explanation, **I do not recommend** that the Applicant be considered for certification. ❑ Explanation Attached

I acknowledge that I AM NOT a member of the applicant's family. I have read the foregoing statements and any document(s) attached, and to the best of my knowledge, the information contained in this form is true and correct.

_____ _____

Supervisor's Signature **Date**