

# DEPARTMENT OF MENTAL HEALTH

State of Mississippi



## MEMORANDUM

TO: Peer Support Specialist Applicant

FROM: Mississippi Department of Mental Health

RE: Certified Peer Support Specialist Professional Application (**Adult and Parent/Caregiver**)

Thank you for your interest in the Mississippi Certified Peer Support Specialist Professional (CPSS) Training. The CPSS training includes three hours of online requisite courses and an intensive classroom four-day training. Completion and attendance at all sessions is required along with successfully passing an exam to be certified.

The training is not a job placement program and completion of the training does not guarantee that you will be hired as a CPSS. Once you have completed the training, you will need to apply for positions that are available.

Program participants will be chosen based upon meeting the program's selection criteria, timely submission of the application and responses to application questions. Priorities will be given to applicants who are employed or referred by a Department of Mental Health Certified Provider.

The CPSS application is attached. As the information requested on the application is lengthy, please carefully review and submit the completed original application including all required attachments and fees to:

**Mississippi Department of Mental Health**  
**ATTN: Aurora Baugh**  
**Certified Peer Support Specialist Program**  
**239 North Lamar Street**  
**1101 Robert E. Lee Building**  
**Jackson, MS 39201**  
Email: [Aurora.Baugh@dmh.ms.gov](mailto:Aurora.Baugh@dmh.ms.gov)  
**601-359-1288**

### **SCHOLARSHIP**

Scholarships are limited and granted based on availability of funds.



**Mississippi Department of Mental Health**

**CERTIFIED PEER SUPPORT  
SPECIALIST PROFESSIONAL  
APPLICATION**

# TABLE OF CONTENTS

This packet includes everything you will need to apply for the Mississippi Peer Support Specialist Professional Training. There are several steps to this process which are clearly outlined. **Please read all instructions carefully before you begin.**

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## INSTRUCTIONS

Please read instructions carefully before you begin.

You should have completed the CPSS Discovery Guide as part of a pre-requisite to help you decide if participating in the Peer Support Specialist Professional Training makes sense for you at this time. If you did not complete the Discovery Guide, please go back at this time and re-review the video "How to become a CPSS".

The Peer Support Specialist Professional Training requires a significant commitment of time and energy. Significant amounts of reading, homework, review worksheets, full participation, and a final exam will be required. Please consider your ability to commit time and energy to this project before continuing.

If accepted into the program, you will be expected to attend and actively participate in the full four-day training and participate in discussion and role plays utilizing your personal experiences and sharing your recovery and/or support story. Failure to attend the entire training will result in the need to retake the entire course. Please understand that you are not guaranteed employment or a volunteer position as a result of participating in the training.

## CERTIFIED PEER SUPPORT SPECIALIST DISCOVERY GUIDE

The job of peer support specialist is to help instill the hope of recovery, in part by being able to demonstrate or model recovery skills they have learned. In Mississippi a person wanting to become a peer specialist must complete a 4 day training program and pass a written exam, but the “expertise” a peer has comes not from a book or training program but from having “walked the walk”.

A peer specialist must be aware of, able to publicly describe and role model to others the things that they learned that helped them to recovery

**To help decide if you are ready for peer specialist training, please answer the YES/NO questions below. A “YES” answer means you are willing and prepared to give a detailed response.**

		YES	NO
1	Are you willing to disclose to individuals receiving services, staff and the general public that you have been diagnosed with a mental illness, addition disorder or both?		
2	Can you describe in detail what has helped you to move from where you were to where you are now?		
3	Can you describe what you have had to overcome to get where you are today?		
4	Can you describe some of the things that you do daily to keep yourself on the right path?		
5	Can you describe what your diagnosis means, how it impacted your life and what things you did to change that?		
6	Can you describe the purpose of your medications, any side affects you experienced and plans you developed to deal with them? (If you do not take medication leave blank)		
7	Do you have any type of written wellness plan? Can you describe what it was like to put one together and how it has helped you		
8	Can you describe some of the beliefs and values you have or have developed that helps to strengthen your recovery and why do you believe they do?		
9	Do you believe that you could talk to a person to help them understand recovery or try to convince someone who did not believe in recovery that it is possible?		
10	Can you describe some of the things you have found helpful in combating negative self-talk?		
11	Do you have a Wellness Recovery Action Plan or other type of written wellness plan? Can you describe what it was like to put one together and how it has helped you?		
12	Do you believe that you could talk to a person to help them understand recovery and resiliency?		
13	Can you describe the role that a sense of hope and resiliency played in your life, your recovery?		
14	Can you describe some of the community supports you have and how they help you deal with your mental illness/addiction?		
15	Can you describe how you deal with crisis? With recurrence of your symptoms?		

		YES	NO
	With relapse?		
16	Have you ever led a support group? Can you describe what you liked about it?		
17	Do you have experience leading a community based support organizations like, NAMI-MS, Mental Health Association, Alcoholic Anonymous 12 Step Program? Can you discuss how they supported/helped your recovery efforts?		
18	Have you attended and/or spoke at any conferences on mental health and/or addictions in the last three years?		

**If you answered no to eight (8) or more questions you may not be ready to participate in the peer specialist training at this time. We suggest that you check out the recovery programs available at your local mental health center, NAMI, Mental Health Association, The Arc of Mississippi, Mississippi Families As Allies, etc.**

*Being grounded in your own recovery is the best step you can take to help others become grounded in theirs.*

# APPLICATION FORM for Certified Peer Support Specialist Professional (CPSS)

CPSSP Adult

CPSSP-Parent/Caregiver

**Directions:** This form is to be completed by the Applicant. Type or print **ALL INFORMATION**; fill in every blank and/or check the appropriate boxes. The application **MUST BE** properly notarized and signed by the Applicant or the Applicant's legal representative, if applicable.

### Personal Information

Name:  Mr.  Ms. \_\_\_\_\_  
(Type or Print name used on records and as it should appear on the certificate.)

Home <u>Street Address</u>		
City, State, Zip		
<u>County of Residence</u>		
Numbers	Home Number:	Cell/Work Number:
Email Address		

**An accurate mailing address is mandatory. The Division of Recovery & Resiliency must be notified of any address changes during the certification process.**

**I would like to apply for a scholarship**

### Experience Information

Applicant must, within the last three years (not necessarily consecutively), have a minimum of 100-250 hours of paid or volunteer work or activities in a support or advisory role with and adult diagnosed with a serious mental illness, substance use disorder, intellectual/developmental disability adults, transition age youth or parent/caregiver.

Position (Most Recent)		
Organization		
Street Address		
City, State, Zip		
Telephone Number		
Time Frame	From _____ to _____ # hours/week _____	
Responsibilities		

Experience Information	
Position	
Organization	
Street Address	
City, State, Zip	
Telephone Number	
Time Frame	From _____ to _____ # hours/week _____
Responsibilities	

Position	
Organization	
Street Address	
City, State, Zip	
Telephone Number	
Time Frame	From _____ to _____ # hours/week _____
Responsibilities	

Education Information	
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The applicant must provide documentation of a minimum of a high school diploma, GED certificate or be at least sixteen (16) years of age and enrolled in a GED program or enrolled in school.

My official transcript(s), high school diploma or GED is included in this application packet.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I am currently enrolled in school or a GED program and verification of enrollment is included in this application packet. <b>(Individuals seeking to work with transition age youth only.)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Disclosures**

I am comfortable and willing to self-disclose for the purpose of education, role modeling and providing hope to others about the reality of wellness and resiliency that I am a:

- family member                       a person currently receiving services for mental illness
- parent/caregiver                       a person currently receiving services for substance use
- a person currently receiving services for intellectual/developmental disabilities

I have demonstrated a minimum of six (6) consecutive months out of the last twelve (12) months (check all that applies):

- self-directed wellness and/or resiliency;
- supporting the wellness and/or resiliency process of a family member;
- supporting the wellness and/or resiliency of an individual living with mental illness, substance use, and/or intellectual and developmental disability

*My signature below affirms that all of the information contained in this application is true and correct to the best of my knowledge and has been completed by no other person. I understand that knowingly providing false information shall be grounds to deny or revoke my certification.*

\_\_\_\_\_  
Applicant's Signature Date

\_\_\_\_\_  
Legal Representative's Signature Date  
(If applicable, please provide documentation)

**APPLICATION MUST BE NOTARIZED BELOW:  
-AFFIDAVIT-**

**State of** \_\_\_\_\_ **County of** \_\_\_\_\_

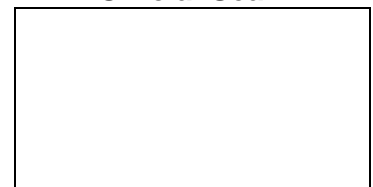
The undersigned, being sworn, deposes and says that he/she is the person who completed this application; that the statements contained herein are true in every respect; **that he/she has read the DMH Peer Support Specialist Professional Standards & Requirements document and the DMH Peer Support Specialist Professional Principles of Ethical & Professional Conduct and will conform to these Standards & 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 he/she understands that upon certification, certain certification data are considered public information; that he/she releases DMH (and its representatives) from all liability and claims arising from any services (if any) rendered by the undersigned; that he/she has read and understood this affidavit; that he/she understands that all application materials become the property of DMH and will not be returned; and, that he/she understands that the application fee is nonrefundable/nontransferable.

**Applicant's Signature** \_\_\_\_\_

Day of \_\_\_\_\_, 20\_\_\_\_\_.

**Signature of Notary Public My commission expires on** \_\_\_\_\_

**Official Seal**





## Assurance and Release

The Department of Mental Health, PLACE Review Board reserves the right to request further information from all employers and other persons listed on the application form. The Board and its review committees also reserve the option of requesting an oral interview with the applicant. This information will be used strictly to evaluate the professional competence of the applicant and will be kept confidential by the Board. Further information may also be requested to verify training, employment history, etc. This information is not available to others outside of the certification process without written consent from the applicant.

"I give my permission for the PLACE Review Board and its staff to investigate my background as it relates to statements contained in this application. I understand that intentionally false or misleading statements or intentional omissions shall result in the denial or revocation of certification."

"I consent to the release of information contained in my application, certification file or other pertinent data submitted to or collected by the PLACE Review Board to officers, members and staff of the aforementioned Board."

"I further agree to hold the PLACE Review Board, its officers, Board members, employees and examiners 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 subsequent examinations and/or failure of the PLACE Review Board to issue certification."

"I am publicly disclosing myself as a first degree family member or a current or former recipient of mental health and/or substance use or intellectual/developmental disability services. Upon award of certification, I understand that my name and my certification status will be included in a public-access database of Certified Peer Support Specialist Professionals."

"I hereby affirm that the information provided on this form is correct and that I believe that I am qualified for the level of certification for which I am applying."

***My signature below affirms that all of the information contained in this application is true and correct to the best of my knowledge and has been completed applicant. I understand that knowingly providing false information shall be grounds to deny or revoke my certification.***

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Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Legal Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If applicable, please provide documentation)

# DMH CERTIFIED PEER SUPPORT SPECIALIST PROFESSIONAL REFERENCE FORM

**Directions:** Thank you for taking the time to provide a reference and recommendation for certification to this applicant as he or she applies for the Department of Mental Health Certified Peer Support Specialist Professional Credential. Your feedback is a critical component of the application process and is greatly appreciated.

1. Based on your relationship and experiences with the applicant, carefully consider his or her appropriateness for the role. With this in mind, please complete the CPSSP Reference Form. By your signature at the bottom of the form, you are attesting that the applicant is someone you would recommend for certification.
2. Once the reference is completed, place the form in an envelope, seal the envelope, sign the seal of the envelope with your signature, and return the envelope to the applicant so it can be submitted with the application.
3. Applicant must submit two references: (1-professional & 1-personal). If you have any questions please contact our office at 601-359-6693.

Applicant's Name: \_\_\_\_\_

1. Please describe the nature of your relationship with the applicant.  Professional  Personal (select one)

\_\_\_\_\_

\_\_\_\_\_

2. How long have you known the applicant? \_\_\_\_\_

3. Please describe the strengths and any potential weaknesses of the applicant and his or her ability to provide services as a Certified Peer Support Specialist Professional.

\_\_\_\_\_

\_\_\_\_\_

4. Please comment on only the items listed below which you can personally respond and check off the most appropriate rating of the applicant's abilities.

	Strong	Moderately Strong	Limited
Academic Ability			
Written Communication			
Oral Communication			
Ability To Help Others			
Stress Management Abilities			

**REFERENCE CONTACT INFORMATION: (Please print/type)**

Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ Work Phone: \_\_\_\_\_

My signature below affirms that all of the information contained in this document is true, and that I support this application without reservation.

\_\_\_\_\_  
Signature of Reference

\_\_\_\_\_  
Date

# DMH CERTIFIED PEER SUPPORT SPECIALIST PROFESSIONAL REFERENCE FORM

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3. Please describe the strengths and any potential weaknesses of the applicant and his or her ability to provide services as a Certified Peer Support Specialist Professional.

\_\_\_\_\_

\_\_\_\_\_

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Ability To Help Others			
Stress Management Abilities			

**REFERENCE CONTACT INFORMATION: (Please print/type)**

Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ Work Phone: \_\_\_\_\_

My signature below affirms that all of the information contained in this document is true, and that I support this application without reservation.

\_\_\_\_\_  
Signature of Reference

\_\_\_\_\_  
Date

## INFORMATION GATHERING FORM

**Please answer the following questions on your own. Your answers can be brief but you must use complete sentences. Your handwriting must be legible.** If you need additional space for your answers, attach a separate sheet of paper.

1. In your own words, what does wellness mean to you? What factors were important in providing support to a family member?

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2. Why do you want to become a Certified Peer Support Specialist?

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3. Peer specialists are models of wellness and/or resiliency for others. In what ways do you demonstrate wellness and its goal of a full and meaningful life in the community?

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4. What types of experiences have you had in advocating for your child? Please describe in detail, listing efforts, personal advocacy, hope, support, public testimony, programs you began, or the work you are doing now. Be specific.

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5. If you obtain employment as a Certified Peer Support Specialist, how would you feel about sharing/disclosing parts of your wellness story with the people you support? Please describe your comfort level, avoiding single word answers.

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6. Describe what strengths you would bring to the position and what skills you feel you need to develop.

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My signature affirms that all answers in the Peer Support Specialist Information Gathering Form are true to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Representative (if applicable)

\_\_\_\_\_  
Date

If you have additional questions, please contact the Mississippi Department of Mental Health, 601-359-1288.

**Mail to:**

**Mississippi Department of Mental Health  
ATTN: Aurora Baugh  
Certified Peer Support Specialist Program  
239 North Lamar Street  
1101 Robert E. Lee Building  
Jackson, MS 39201  
Email: [Aurora.Baugh@dmh.ms.gov](mailto:Aurora.Baugh@dmh.ms.gov)  
601.359.1288**

## **Certified Peer Support Specialist Applicant Checklist**

Please use this as a final self-reminder regarding all the necessary documents and have fully completed all the requirements of the application. This will help you, as well as us, with a quicker review of your application.

- CPSS Application (Notarized)
- Reference Forms (Applicant must submit two references non-family member)
- Official College Transcript or documentation of High School diploma or GED
- Information Gathering Form

# Personal Data Information Form

The information you provide on this form is strictly voluntary. The information collected on this form is treated as highly confidential and will be used for general, statistical and future planning purposes.

Name: \_\_\_\_\_  
                             First                                            MI                                            Last

Birthdate:      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Gender:        Male  Female  Transgender

**Veteran Status:**  
 \_\_\_\_ Not a Veteran  
 \_\_\_\_ Veteran  
 \_\_\_\_ Disabled Veteran  
 \_\_\_\_ Special Disabled Veteran  
 \_\_\_\_ Newly/Recently Separated Veteran (3) years  
 \_\_\_\_ Vietnam-Era Veteran  
 \_\_\_\_ Armed Forces Service Medal Veteran  
 \_\_\_\_ Other Protected Veteran

**Military Reserve:**  
 \_\_\_\_ Active  
 \_\_\_\_ Inactive Reserve (Recall)  
 \_\_\_\_ Inactive Reserve (No Recall)

**Race/Ethnicity:**  
 Are you Hispanic or Latino?  Yes  No

Please select the race you identify with:  
 American Indian or Alaska Native  
 Asian  
 African American/Black  
 Native Hawaiian or Other Pacific Islander  
 Caucasian/White  
 Unknown

Are you fluent in any other language(s) other than English?  YES  NO  
 If yes, what other \_\_\_\_\_

**Sexual Orientation:**  
 (Please select all that apply)

Heterosexual  
 Gay  
 Lesbian  
 Bisexual  
 Other \_\_\_\_\_

**Seeking Certification as:**

Peer Support Specialist  
 Peer Support Specialist -Parent/Caregiver  
 Peer Support Specialist – Youth  
 Peer Support Specialist - Veteran