

Certified Peer Support Specialist Training Application

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|---|--|-------|--------------------------------------|---|--|
| TO BE COMPLETED BY DSAMH | | | | Date application reviewed: _____ | |
| Name: _____ | | | | <input type="checkbox"/> Approved <input type="checkbox"/> Denied Referred to Supervisor <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Please type or print clearly. All sections must be completed for the application to be processed. | | | | | |
| Confidentiality Statement: <i>The information you provide on this page, your written personal statements and letters of reference will be treated as confidential information. They will only be available to authorized DSAMH and Training Program Staff from the Training Program selected on this application, for the purpose of enrollment to the CPSS Training.</i> | | | | | |
| In which CPSS Training Program(s) do you want to enroll? (mark all that apply) <input type="checkbox"/> Optum Health CPSS Training - primarily for residents of Salt Lake County <input type="checkbox"/> University of Utah School of Social Work CPSS Training <input type="checkbox"/> Utah State University CPSS Training Program <input type="checkbox"/> Veteran's Administration CPSS Training | | | | | |
| DEMOGRAPHIC INFORMATION | | | | | |
| Applicant's Name Last First Middle Initial | | | Daytime Telephone Number | | |
| Mailing Address | | | Phone Number | | |
| City | | State | | Zip Code | |
| County | | | Highest level of education completed | | |
| SELF IDENTIFYING | | | | | |
| Ethnicity (optional) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____ | | | | | |
| <i>"Individual in Recovery" includes: A person self-identified as "in recovery" who has applied for, is eligible for, or has received mental health and/or substance use services currently or in the past.</i> <input type="checkbox"/> I agree that I am an "Individual in Recovery" based on the definition as stated, and I am 18 years of age or older. | | | | | |
| Volunteer Organization/Employer Name (if applicable) | | | | <input type="checkbox"/> Please check box if you are a veteran | |
| Please provide at least two letters of reference. One letter should be from a clinical professional that the applicant has recently received services from and should describe where the applicant is in the recovery process. Attach the letters to the application. | | | | | |
| The following questions should be answered on a separate piece of paper and should consist of at least several paragraphs. Please type responses and attach to the application. | | | | | |
| <ol style="list-style-type: none"> 1. Provide a history of your recovery journey. 2. Describe what you are doing to remain in recovery. Please include 4 or 5 examples. 3. In what ways have you assisted others using your own experience as an example? | | | | | |
| Please sign and date this document to indicate your understanding of each of the following: | | | | | |
| <ul style="list-style-type: none"> • If I am chosen as a training participant, I understand that I am responsible for my own expenses, such as and not limited to: tuition/registration fees, travel, hotel accommodations, and meals unless otherwise specified. • I understand that training slots are limited and therefore submission of this application does not guarantee admission. • I understand that I must pass a written exam within two months of completing the 40-hour classroom training. • I understand that as a certified peer support specialist it does not guarantee employment. | | | | | |
| EQUAL OPPORTUNITY STATEMENT | | | | | |
| <i>The Division of Substance Abuse and Mental Health provides equal opportunity for all applicants regardless of race, color, creed, religion, national origin, sexual orientation, veteran status, gender, disability status or age.</i> | | | | | |
| SIGNATURE | | | DATE | | |

Mail, E-mail, or Fax completed application, letters of recommendation and other attachments as specified to:

Division of Substance Abuse and Mental Health (DSAMH)
 Attn: Utah Certified Peer Support Specialist (CPPS Program)
 195 North 1950 West
 Salt Lake City, UT 84116
 Email: utahpeersupport@utah.gov

Fax: (801)538-4696
 Phone: (801)538-3939