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**YOUTH PEER SUPPORT**

**TRAINING REGISTRATION PACKET**

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* YPSS Pre-Training Questions

For each YPSS attending training, a completed registration packet must be submitted to ACMH no later than three weeks prior to the first day of training.

Please email completed packet to:

 Krissy Dristy, Program Manager for YPS and PSP: kdristy@acmh-mi.org

AND

Mandy gernard, Admin Asst: mgernard@acmh-mi.org

Alternately, packets can be faxed or mailed:

Fax: 517.372.4032

Mail: ACMH – 6017 W St Joe Hwy Ste 200, Lansing MI 48917

***Youth Peer Support***

***Training Registration Form***

|  |  |
| --- | --- |
| **Training Date or Cohort YPSS will attend** |  |

|  |  |
| --- | --- |
| **PIHP** |  |
| **CMHSP**  |  |
| **Street Address**  |  |
| **City ST Zip** |  |

|  |  |
| --- | --- |
| **Family/Contract Organization** (if applicable) |  |
| **Street Address**  |  |
| **City ST Zip** |  |

|  |  |
| --- | --- |
| **YPSS Name:** |  |
| **Work Email** |  |
| **Hire Date** |  |
| **Dietary Needs** |  |
| **Other Needs** |  |

|  |  |
| --- | --- |
| **Name of person who will supervise YPSS)** |  |
| **Name of clinical supervisor (if different)** |  |

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**Association for Children’s Mental Health
in partnership with
Michigan Department of Health and Human Services**

**Hiring Expectations Agency Agreement**

Following are the expectations for the agencies that hire and employ Parent Support Partners (PSP) and Youth Peer Support Specialists (YPSS).

* The PSP/YPSS will be hired and employed by the CMH or contract agency before they attend Part One of training.
* PSP/YPSS and their supervisor will complete a training orientation call with Program Manager/Statewide Coordinator prior to start of cohort training.
* All pre-training paperwork will be completed by the given deadlines (registration, supervisor contact information, media release and emergency contact).
* The agency will assure that their PSP/YPSS(s) have equipment and all technology to perform their job.
* The agency will ensure that YPSS/ PSP is aware that 100% participation in all certification requirements is required. NO EXCEPTIONS.
* If the PSP/YPSS is employed through a family or contract organization, a supervisor from that organization will be identified and will participate in a minimum of monthly supervision with the CMH and PSP/YPSS.
* Employers establish a work schedule that includes a consistent number of hours of work per week and meets the needs and availability of the youth and families being supported.
* The workload will be individualized to assure that individuals receive a high***-***quality PSP/YPSS service.
* The agency will ensure that the PSP/YPSS will be an active member of the treatment team and will participate in team and planning meetings.
* The PSP/YPSS will continue to actively provide this service to a minimum of one youth, parent, or primary caregiver to be seen on a regular and ongoing basis as outlined in the IPOS.
* Upon completing Part One oftraining, the PSP/YPSS will begin to work with parents, caregivers, or youth (as it applies to their position)
* All MDHHS requirements for PSP/YPSS training, Part One and Part Two,and ongoing certification requirements will be met. This includes all MDHHS requirements for recertification.
* Supervisors will attend a new supervisor training and will attend one supervisor roundtable annually, thereafter. Supervisors will continue to participate in additional TA/training as required by the PSP/YPSS model or requested by the Statewide Coordinator.
* Individual supervision will be provided by a qualified children’s mental health professional (CMHP) identified by the agency on a regular basis.

We have read all information in the Hiring Expectations Agreement above, and the information in the YPSS/PSP Certification Requirements, Expectations and Implications document. We understand and agree to all requirements.

[ ]  Hiring Parent Support Partner(s) [ ]  Hiring Youth Peer Support Specialist(s)

|  |
| --- |
|  |
| CMH and/ or Contract Agency Name |
|  |  |  |
| Program Director Signature  |  | Date |
|  |  |  |
| YPS/PSP Supervisor Signature |  | Date |

|  |
| --- |
| **Youth Peer Support Supervisor** |
| **Contact Information** |

**PRIMARY CMH SUPERVISOR - Provides Clinical Supervision to YPSS**

|  |  |  |
| --- | --- | --- |
| **CMHSP** |  | **Share?** |
| **Name**  |  |[ ]
| **I prefer to be called *(nickname if applicable)*** |  |[ ]
| **Worksite Address** |  |[ ]
| **Mailing Address (if different)** |  |[ ]
| **Primary phone:** |  | [ ] Office [ ]  Cell[ ] Other (specify)  |[ ]
| **Alternate phone** |  | [ ] Office [ ]  Cell[ ] Other (specify) |[ ]
| **email** |  |[ ]
| **For last minute cancellation/update of a supervisor or YPS event, how would you like to be notified?** |  |
| **Do you want any of your contact information shared with other YPS Supervisors? List here or check “share” box(es) above.** (name, agency-title, phone/s, email, address) |  |

**ADDITIONAL SUPERVISORS of YPSS (if applicable)**

|  |  |  |
| --- | --- | --- |
| **CMHSP/Agency** |  | **Share?** |
| **Name**  |  |[ ]
| **I prefer to be called *(nickname if applicable)*** |  |[ ]
| **Worksite Address** |  |[ ]
| **Mailing Address (if different)** |  |[ ]
| **Primary phone:** |  | [ ] Office [ ]  Cell[ ] Other (specify) |[ ]
| **Alternate phone** |  | [ ] Office [ ]  Cell[ ] Other (specify) |[ ]
| **email** |  |[ ]
| **For last minute cancellation/update of a supervisor or YPS event, how would you like to be notified?** |  |
| **Do you want any of your contact information shared with other YPS Supervisors? List here or check “share” box(es) above.** (name, agency-title, phone/s, email, address) |  |

|  |
| --- |
| **Youth Peer Support Specialist** |
| **Contact Information** |

|  |  |
| --- | --- |
|  | **Share?** |
| **YPSS Name**  |  |[ ]
| **I prefer to be called *(nickname if applicable)*** |  |[ ]
| **Worksite Address** |  |
| **Mailing Address (if different)** |  |
| **Primary phone:** |  | [ ] Office [ ]  Cell[ ] Other (specify) |[ ]
| **Alternate phone** |  | [ ] Office [ ]  Cell[ ] Other (specify) |[ ]
| **Work email** |  |[ ]
| **Agency**  |  |[ ]
| **Supervisor Name** |  |
| **For last minute cancellation/update of a YPS event, how would you like to be notified?** |  |
| **Do you want any of your contact information shared with other YPSSs? List here or check “share” box(es) above.**(name, agency-title, phone/s, email, address) |  |



**Media Release Form**

*For the use of name, photographs, videotape, and quotations*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my permission for the Association for Children’s Mental Health to print or publish (including electronically), or share via ACMH social media platforms my name, artwork, poetry, photographs, and video of me and/or to use quotations from me.

|  |  |
| --- | --- |
| Participant Signature:  |  |
| Date:  |  |

**Emergency Contact**

|  |  |
| --- | --- |
| Contact Name |  |
| Relationship |  |
| Home Phone  |  | Cell Phone |  |
| Work Phone |  | Other Info? |  |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Association for Children’s Mental Health, to contact the contact listed above should a situation arise while I am at an ACMH function which the Executive director or designee deem to be an emergency.

|  |  |
| --- | --- |
| Participant Signature:  |  |
| Date:  |  |

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**Youth Peer Support Specialist (YPSS)
Pre-Training Questions**

|  |  |
| --- | --- |
| Name:  |  |
| Employer |  |

|  |
| --- |
| Why do you want to be a YPSS? |
|  |
| Can you share a time when you felt hope in your mental health journey? |
|  |
| What do you hope to learn at the training? What questions do you hope will be answered about your role? |
|  |
| What strengths will you bring to your role as a YPSS? |
|  |