ASSOCIATION FOR CHILDREN'S MENTAL HEALTH
ACMH
Hope for Families, Shaped by Lived Experience

Agency Information

PIHP: ..... **CMHSP:** .....

County(ies) Peer will serve: .....

Address: .....

Family/Contract Organization (if applicable) : .....

Address: .....

Primary CMH Supervisor-Provides Clinical Supervision to Peer Professional

Full Name: ..... **Email:** .....

Work Address: .....

Mailing Address: .....
(if different)

Primary Phone: ..... ☐ Office ☐ Cell

Alternate Phone: ..... ☐ Office ☐ Cell

☐ **Please indicate if this is a new supervisor.**

☐ **Please indicate if you plan to join us for lunch.**

Supervisor Dietary Needs:

☐ None ☐ Vegetarian ☐ Allergies/Other (Please list): .....

While we will make reasonable efforts to accommodate dietary needs, accommodations are based on vendor availability and preparation practices. Participants with severe allergies may wish to take additional precautions.

Additional Supervisor (if applicable)

Full Name: ..... **Email:** .....

Work Address: .....

Mailing Address: .....
(if different)

Primary Phone: ..... ☐ Office ☐ Cell

Alternate Phone: ..... ☐ Office ☐ Cell

☐ **Please indicate if this is a new supervisor.**

Agency contact in case of last minute cancellation/other event:

Full Name: ..... **Contact:** .....

Please indicate the type Peer Professional you are registering:

☐ Parent Support Partner (PSP)
☐ Youth Peer Support Specialist (YPSS)
☐ Family Crisis Response Peer (FCRP)

Date of Cohort Training: .....

Please indicate the type Peer Professional service(s) your agency has experience providing:

☐ Parent Support Partner (PSP)
☐ Youth Peer Support (YPS)
☐ Family Crisis Response Peer (FCRP)

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Peer Information:

Full Name: ..... **Email:** .....

Work Address: .....

Mailing Address: .....
(if different):

Primary Phone: ..... ☐ Office ☐ Cell

Alternate Phone: ..... ☐ Office ☐ Cell

Which option best describes your racial identity:

- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Single Race (please specify below)
- ☐ Two or More Races (please specify below)
- ☐ I prefer not to disclose
- ☐ Hispanic or Latin or Spanish Origin of any race
- ☐ Other (please specify below)

Other (please specify): .....

Sex: ☐ Male ☐ Female ☐ Not Listed ☐ I prefer not to disclose.

Please indicate which meals you plan to attend:

- ☐ Day 1 Lunch
- ☐ Day 1 Dinner
- ☐ Day 2 Lunch
- ☐ Day 2 Dinner
- ☐ Day 3 Lunch

Peer's Dietary Needs:

☐ None ☐ Vegetarian ☐ Allergies/Other (Please list): .....

While we will make reasonable efforts to accommodate dietary needs, accommodations are based on vendor availability and preparation practices. Participants with severe allergies may wish to take additional precautions.

Accessibility & Participation Needs: ☐ Yes (Please describe): .....

.....

Do you have any accessibility or participation-related needs that ACMH may be able to assist with for this training? Please note that this question is intended for accommodations related to the training environment or participation (e.g., mobility access, sensory considerations, technology needs). We may not be able to accommodate all requests.

Peer's Emergency Contact:

Name: ..... **Relationship:** .....

Primary Phone: ..... ☐ Cell ☐ Work ☐ Home

Alternate Phone: ..... ☐ Cell ☐ Work ☐ Home

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

Signature: ..... **Date:** .....

Media Release:

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.

Signature: ..... **Date:** .....

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 Crisis Support Partners (CSP).

- The CSP will be hired and employed by the CMH or contract agency before they attend training.
- CSP and their supervisor will complete a training orientation call with Director of Peer Programs 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 CSP(s) have equipment and all technology to perform their job.
- The agency will ensure that CSP is aware that 100% participation in all certification requirements is required. NO EXCEPTIONS.
- If the CSP 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 CSP.
- 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 CSP service.
- The agency will ensure that the CSP will be an active member of the mobile crisis response team and will participate in team and planning meetings.
- All MDHHS requirements for CSP training 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 CSP model or requested by the Director of Peer Programs.
- 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 CSP Certification Requirements, Expectations and Implications document. We understand and agree to all requirements.

CMH/Agency: _____

Peer Provider Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

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?