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:** .....