Wyoming Certified Peer Specialist

Initial Certification Application

Current Endorsements (check any that apply):

☐ Mastery ☐ Forensic ☐ Whole Health

Peer Specialist's Experience Areas (check any that apply):

☐ Mental Health ☐ Substance Use Disorder ☐ Dual Diagnosis ☐ Recovery Support

Peer Specialist Information

Today's Date:

PART 1: GENERAL INFORMATION

Name for Certificate:

Mailing Address:

City, State, Zip:

Did you, or do you plan to, live in Wyoming for at least 51% of the year? ☐ Yes ☐ No

Phone Number:

Email:

Name of Current Employer:

Employer Address:

Does this organization bill client services to Medicaid?

Agency Director's Name:

Peer Specialist's Direct Supervisor [Licensing credentials if applicable (i.e., LCSW, LPC)]:

Please briefly describe the supervision that the Peer Specialist will receive:

Expiration Date of Wyoming Department of Health Issued Certificate (If applicable):

PART 2: EDUCATION & TRAINING

Education

High School:

Date of Graduation/GED or equivalent:

Other college/trade school information:

*Note a high school diploma or equivalent is required to obtain certification.

Initial Introductory Training

Date when Initial Peer Specialist Training was completed:

Name of Training:

City where it was held:

Name(s) of training facilitators:

Did the training last at least 46 contact hours? (or 36 contact hours if eligible for grandparenting period)

Did the training include topics listed in the following IC&RC domains:

Advocacy (10 hours), Recovery/Wellness Support (10 hours), Mentoring & Education (10 hours), Ethical Responsibility (16 hours)?

*Please attach certificate of completion verifying introductory training completion.

PART 3: EXPERIENCE & SUPERVISION

Work/Volunteer Experience

(500 hours required related to the 4 IC&RC Domains)

Name(s) of Agency/Organization where hours were completed:

1.) Name: Address & Phone:

2.) Name: Address & Phone:

3.) Name: Address & Phone:

*The 500 work/volunteer hours must have occurred within the past two years. Please attach letters of verification of hours.

Supervision

(25 hours of supervision related to the 4 IC&RC Domains)

Name(s)/Contact Information for Supervisor(s):

1.) Name: Address & Phone:

2.) Name: Address & Phone:

3.) Name: Address & Phone:

*Please attach letters of verification regarding supervision hours.

PART 4: LIVED EXPERIENCE

Please list your recovery date:

Please describe how you will use your personal lived experience to help others achieve recovery from mental health and/or substance use disorders:

PART 5: ENDORSEMENTS

List training certification dates for any Forensic, Whole Health, or Mastery Endorsements:

PART 6: PEER SPECIALIST PROGRAM INFORMATION

What do you like best about your position as a Peer Specialist?

What do you like least about your position as a Peer Specialist?

What training opportunities would you like to see available to enhance your skills as a Peer Specialist?

By signing below, I certify that I will adhere to the Wyoming Certified Peer Specialist Code of Ethical Conduct and to improve my competency as a Peer Specialist. I have been or am a consumer of mental health, substance use disorder, or dual diagnosis services; I am well grounded in my recovery; I hold a high school diploma or equivalent; I am at least 18 years of age; and that all of the information above is true and complete.

I understand that meeting these requirements allows the organization for which I work to bill Wyoming Medicaid for Peer Specialist services that are provided by me to clients with Medicaid coverage when these services are identified within the client's treatment plan and if the organization is a Medicaid provider.

Name (Printed)	Signature	Today's Date

Internal Use Only

Date Application Received:_____

Processed by:_____

☐ **Approved** ☐ **Not Approved**

Please mail full application packet to:

Recover Wyoming
Attn: Peer Specialist Certification
122 West Lincolnway
Cheyenne, WY 82001

or Fax to : (307) 222-0281