

# Wyoming Peer Specialist Qualifications Form

This information is for (check one)

- New Hire Qualifications  
 Initial Qualifications  
 Re-Qualified

Check if applicable

- Family Support Peer Specialist  
 Mastery Endorsement  
 Whole Health Endorsement  
 Forensic Endorsement

Peer Specialist's Experience Area(s):

- Mental Health  Substance Abuse Addiction  Dual Diagnoses  Family Experience

## Part 1: General Information (all peer specialists)

Today's Date

### Peer Specialist:

Name for certificate:

Work mailing address:

Town State WY Zip

Phone Number

Email

Date when you first were hired as a peer specialist:

Name of Organization where employed:

Does this Organization bill client services to Medicaid?

Center Director's Name:

Please attach a letter of recommendation from the organization's director

Name of person who directly supervises the Peer Specialist:

Licensing credentials if applicable (i.e. LCSW, LPC):

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

If applying for Re-qualification, expiration date:

Average number of hours worked per month as a peer specialist during the past year:

**All applicants, please add updated information about these requirements.**

1. At a minimum, the applicant must have completed an orientation provided by their employer that includes policies and procedures about confidentiality and ethics. It is good practice to update this information annually.

\*Latest date when peer specialist completed confidentiality and ethics training:

2. A Wellness Recovery Action Plan (WRAP®) must be completed by the applicant within 30 days of hire.

\*Date when Peer Specialist's Wellness Recovery Action Plan (Wrap®) or equivalent was completed and name of the WRAP instructor:

*(New applicants: Attach copy of WRAP certificate or include completion information in Director's letter. Do **not** send your WRAP. Only send the certificate or a letter that shows it was completed. Re-applicants: Note number of people you helped with WRAP this past year.)*

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**Part 2: FOR INITIAL QUALIFICATION ONLY**

*Peer Specialists must complete Initial Qualification requirement within six months of hire. Please see "Wyoming Peer Specialist Qualification Requirements" for more information. Please attach certificates of attendance.*

**1. Introductory Training:**

Date when Peer Specialist Introductory Training was completed:

Name of Training:

City where it was held:

Name(s) of training facilitators:

Did the training last at least 32 contact hours?

For FSPS's, did training last at least 24 hours for HFWA plus 16 hours for FSP?

Check the topics that the training included:

- The recovery process
- How peer specialists share their own recovery stories to promote recovery
- The meaning and role of peer support
- Skills for establishing healing relationships and support systems
- The role of WRAP®
- Self-determination and consumer self-direction
- High Fidelity Wraparound
- Family Support Partner
- Other:

**2. Local Training (2 required during previous 6 months)**

Dates

Topic(s)

1

2

*Please attach up to two pages of documentation such as a certificate of attendance for each local training.*

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**Part 3: FOR CONTINUED QUALIFICATIONS ONLY  
(Submit annually during March)**

1. Date when Behavioral Health Division's Peer Specialist Annual Training was last attended:
  
2. Date when other statewide, regional, or national training was attended (training out of current workplace—preferably out of town):

Name of Training:

Town where it was held:

*Please attach certificate showing completion of training and the agenda*

3. Local Training (3 required during previous 12 months—must include other people):

|   | Dates | Topic(s) |
|---|-------|----------|
| 1 |       |          |
| 2 |       |          |
| 3 |       |          |

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*Please attach up to two pages of documentation such as a certificate of attendance for each local training.*

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**FOR FAMILY SUPPORT PEER SPECIALISTS**

*Within 18 months of hire, Family Support Peer Specialists (FSPS) must complete twelve months of Family Support Partner (FSP) coaching, with a minimum of one hour of FSP coaching each month, provided by a person credentialed by the division as a Family Support Partner Coach. Within 20 months of hire, FSPS's must be receive Family Support Partner credentials from the Behavioral Health Division. Annually, additional FSP training may be required as specified by the Division.*

Please summarize your accomplishments towards these requirements:

**Part 4: FOR MASTERY ENDORSEMENT**

*A Mastery Endorsement may be applied for annually in addition to meeting regular qualifications. Two criteria are required for the Mastery Endorsement. Please see the "Wyoming Peer Specialist Qualification Requirements" for Mastery Endorsement criteria.*

|   | Dates | Criteria Completed (summary) | Location |
|---|-------|------------------------------|----------|
| 1 | -     |                              |          |
| 2 | -     |                              |          |

*Please attach up to three (3) pages of information documenting mastery activities. i.e. newspaper clippings, certificate of attendance, documentation letter, etc.*

**Part 5: FOR OTHER ENDORSEMENTS**

*Please complete if applying for **Whole Health Endorsement***

Date when WHAM (or other pre-approved) facilitator training was last completed:  
Please initial if you presented the WHAM curriculum to at least 4 peers/families during the previous 12 months to include at least 8 weeks of in-person group sessions, each lasting about an hour:

Please initial if you personally attempted one health activity during the 8 week WHAM group as a participating member of the group:

*Please complete if applying for **Forensic Peer Specialist Endorsement***

Date when Forensic Peer Specialist training of at least eight hours was last completed:  
Please initial if you worked as a peer specialist with at least 2 persons who are on probation or parole, in the community, during the past 12 months to include at least 8 one-hour sessions of in-person peer specialist services:

**Part 6:**

**Please provide the following information to assist with improvement and maintenance of the Peer Specialist program.**

1. What I like best about my peer specialist position:
2. What I like least about my peer specialist position:
3. Training that I could use during the next year:
4. One thing that the Behavioral Health Division could do differently to help the Peer Specialist program:

**By signing below** I certify that I am currently employed as a Peer Specialist at a Wyoming Mental Health and/or Substance Abuse Center or other program that receives treatment funding from the Behavioral Health Division. My employer has assigned work to me that is appropriate to my experience and background; I have been or am a consumer of mental health or dual diagnoses or substance abuse addiction services or, if an FSPS, a parent whose child has experienced

system challenges, and I am well rounded in my recovery; I hold a high school diploma or equivalent; I am at least 21 years of age or older; and that all of the information 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

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**Center/Organization Director Endorsement**

By signing below I certify that this person is currently employed by the Center/Organization as a Peer Specialist. The Center/Organization has established criteria to hire, train, and retain the Peer Specialist and that this information is utilized within the candidate's employment; that the Center shall utilize grant or other funds to pay for the candidate's required training and travel needs; that a supervisor provides employment support for the Peer Specialist; and that the Center maintains the integrity of the Peer Specialist role as a fully integrated team member who provides highly individualized services in the community and promotes client self-determination and decision-making.

I understand that the Peer Specialist completion of these requirements allows the Community Mental Health or Substance Abuse Treatment Center (or other if a Medicaid mental health provider) to bill Wyoming Medicaid for Peer Specialist Services that are provided by this Peer Specialist to clients with Medicaid coverage when these services are identified within the client's treatment plan.

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

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**Internal BHD Use Only**

Date received \_\_\_\_\_

Notes:

Date letter of findings mailed \_\_\_\_\_

Approved  Not-approved

Processed by: \_\_\_\_\_

Please mail to  
Behavioral Health Division  
Attn: Peer Specialist Information  
6101 Yellowstone Road, Suite 220  
Cheyenne, WY 82002  
For assistance and information call 1-800-535-4006