

**Appendix III**

**Maine Department of Health and Human Services  
Office of Substance Abuse and Mental Health Services  
CIPS Program Core Training Application**

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Town/city: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_

Are you 18 years of age or older? ..... YES \_\_\_ NO \_\_\_

Can you identify yourself as a person who has experienced a mental health challenge that has seriously impacted your life and relationships for an extended period of time?  
YES \_\_\_ NO \_\_\_

What is the highest level of education you have completed?

- |  |   |
|--|---|
| <input type="radio"/> 8 <sup>th</sup> grade or less    | <input type="radio"/> Technical school graduate |
| <input type="radio"/> Some high school                 | <input type="radio"/> Associate degree          |
| <input type="radio"/> High school graduate or GED      | <input type="radio"/> College graduate          |
| <input type="radio"/> Some technical school or college | <input type="radio"/> Postgraduate degree       |

Have you completed Peer Support 101? ..... YES \_\_\_ NO \_\_\_ Date of Training: \_\_\_\_\_  
*and / or*

Have you completed Healthy Connections? . YES \_\_\_ NO \_\_\_ Date of Training: \_\_\_\_\_

**Personal Commitment**

Maine’s Certified Intentional Peer Support Program requires a significant commitment of time and energy. The initial commitment involves completion of a web-based training and 8 days of classroom training. Substantial amounts of reading, homework, full classroom participation, and a proficiency test are required.

**Please consider your ability to commit time and energy to this project before applying.**

Do you plan to pursue certification as a Certified Intentional Peer Support Specialist (CIPSS)? YES \_\_\_ NO \_\_\_

If no – are you interested in the possibility? ..... YES \_\_\_ NO \_\_\_

**Preference will be given to persons who are currently employed/volunteering or have an offer of employment in a peer support position that requires Intentional Peer Support Specialist Certification.**

Are you currently volunteering in a peer support position? ..... YES \_\_\_ NO \_\_\_

Are you currently employed in a peer support position? ..... YES \_\_\_ NO \_\_\_

If not, have you received an offer of employment if trained? Please explain:

---

---

Is this training and certification a requirement for your employment? ..... YES \_\_\_ NO \_\_\_

Please list your current or potential employer or volunteer Agency or Company name:

---

Do you work within any of the following programs (circle)?

ACT Behavioral Health Home Emergency Department PATH  
Peer Center State Hospital Warm Line Other \_\_\_\_\_

Have you received any peer support training through your **current** employer or volunteer work? YES \_\_\_ NO \_\_\_

Have you already attended any Co-Reflections through the CIPS Program? YES \_\_\_ NO \_\_\_

I completed this application myself ..... YES \_\_\_ NO \_\_\_

Someone assisted me to complete this application. .... YES \_\_\_ NO \_\_\_

Someone else completed this application for me. .... YES \_\_\_ NO \_\_\_

Accommodations Requested:

- Large Print
- Scent Free
- Service Animal
- Sign Language Interpreter
- Reader or Audio Recording of Training Materials
- Other \_\_\_\_\_

I understand that all sessions are mandatory.

I commit to participate in the training to the fullest extent of my abilities.

I attest that all answers in this application are true to the best of my knowledge.

**I understand that if I write illegibly or if my answers are only a couple of words or a single sentence, that may lower my score** (we do not need essays, but we need at least a few sentences to get a sense of where you are coming from and your readiness for this training).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer each of the following questions, and remember there are no right or wrong answers. We expect you to be thoughtful and thorough; the questions are intended to inform the committee of your personal perspective.

**Some questions have two parts, scored separately, and a complete answer reflects your skills and experiences. Unanswered questions result in a score of 0.**

If you need additional space for your answers, please include attachments as necessary.

**1. A.** Please list any classes or training you have taken (other than Peer Support 101 or Healthy Connections) that relate to your understanding of wellness, resiliency, recovery, and/or peer support.

Name of Training	Topics Covered	Date(s)	Who provided the training?

**1. B.** Please list any relevant support groups you've been involved in as a participant (not solely as a facilitator or group leader).

---

---

---

---

---

---

2. How do you imagine this training could impact personal life and relationships?

---

---

---

---

---

3. Please describe how you relate to others with different backgrounds and viewpoints, **and** give an example:

---

---

---

---

---

4. What do you think creates well-being for people?

---

---

---

---

---

5. Many of us have found traditional mental health services helpful, such as Medication Management, Therapy, Day Support, Intensive Outpatient, CBT, DBT, Partial Hospitalization; etc. For this question, we would like you to tell us what you do for **your** overall wellbeing, outside of traditional services, **and** how it is helpful?

---

---

---

---

---

---

6. Can you describe a turning point or transformational experience that helped you through a specific mental health challenge, **and** how long ago did that take place?

---

---

---

---

---

---

7. Please describe how you envision using your experience in practicing peer support with other individuals, **and** how it might impact the larger community?

---

---

---

---

---

---

8. Describe an activity you have been involved in that represents commitment **and** follow through.

---

---

---

---

---

9. What will be your greatest challenge in attending and participating in the training **and** how will you address that challenge?

---

---

---

---

---

**PLEASE MAKE A COPY OF THIS APPLICATION TO KEEP FOR YOUR RECORDS.**

If you have any questions about the status of your application please contact Kelly Staples by email at [Kelly.Staples@maine.gov](mailto:Kelly.Staples@maine.gov) or by phone at 207-215-5389

**Return this completed application to the address shown below, together with your three personal references using the form provided.** If you are working or volunteering, at least one of these references must be from a supervisor. Each reference should complete the form, seal it in an envelope, sign his/her name across the seal outside the envelope, and return it to the applicant so it can be included in one package with the application.

Application packages should be mailed to the Recovery Team/SAMHS at the following address:

ATTN: CIPS Program  
Recovery Team/SAMHS  
41 Anthony Avenue  
SHS 11  
Augusta, ME 04333-0011

.....  
The Department of Health and Human Services (“DHHS”) does not discriminate on the basis of disability, race, color, sex, gender, sexual orientation, age, national origin, religious or political belief, ancestry, familial or marital status, genetic information, association, previous assertion of a claim or right, or whistleblower activity, in admission or access to, or the operation of its policies, programs, services, or activities, or in hiring or employment practices. This notice is provided as required by and in accordance with Title II of the Americans with Disabilities Act of 1990 (“ADA”); Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; Age Discrimination Act of 1975; Title IX of the Education Amendments of 1972; Section 1557 of the Affordable Care Act; the Maine Human Rights Act; Executive Order Regarding State of Maine Contracts for Services; and all other laws and regulations prohibiting such discrimination. Questions, concerns, complaints or requests for additional information regarding the ADA and hiring or employment practices may be forwarded to the DHHS ADA/EEO Coordinators at 11 State House Station, Augusta, Maine 04333-0011; 207-287-4289 (V); 207-287-1871(V); or Maine Relay 711 (TTY). Questions, concerns, complaints or requests for additional information regarding the ADA and programs, services, or activities may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-5014 (V); Maine Relay 711 (TTY); or [ADA-CivilRights.DHHS@maine.gov](mailto:ADA-CivilRights.DHHS@maine.gov). Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 800-368-1019 or 800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or electronically at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA/Civil Rights Coordinator. This notice is available in alternate formats, upon request.