



**State of Indiana Family and Social Services Administration (FSSA)/
Division of Mental Health and Addiction (DMHA)**

Certified Parent Support Provider Application

Name *(please print)* _____

Address _____

City _____ State _____ ZIP _____

Email _____ Phone _____ Cell _____

Child[ren]'s D.O.B.: _____

All applicants will be expected to submit to the following screenings after the training and the passing of the Parent Support Provider exam as part of the certification requirements :

- Finger-print based national and state criminal history background screen
- Local law enforcement screen
- State and local Department of Child Services abuse registry screen
- 5- Panel Drug Screen

All applicants must complete the following application and meet all of the eligibility requirements in order to participate in the Certified Parent Support Provider training program.

1) Do you meet the requirement of being 21 years of age or older? Please attach proof of age.

Yes

No

2) Do you meet the requirement of having a valid Indiana driver's license and reliable transportation? Please bring proof of license.

Yes

No

3) Do you meet the requirement of having earned a high school diploma or GED?

Yes

No

4) Do you meet the requirement of having basic computer skills including Microsoft Office?

Yes

No

5) Are you willing and able to attend 40-hour 5-day training?

Yes

No

6) Are you currently or have you been the parent or guardian of a child or youth between the ages 6-18 diagnosed with a serious emotional disturbance (SED) and/or co-occurring disorder diagnosed by a physician or psychologist?

Yes

No

Name of physician or psychologist _____

7) Have you had at least 2 years experience within the last eight years being the parent/guardian of a child/youth (between the ages 6-18) with a SED and/or co-occurring disorder?

Yes

No

Date (can be approximate) and name of diagnosis _____

8) Please list the systems (school, juvenile justice, Wraparound, mental health system, etc.) you navigated while caring for your child.

_____	_____
_____	_____
_____	_____

9) Please list your strengths (patient, hardworking etc. if you cannot think of any, what would your family/friends say were your strengths)

_____	_____
_____	_____
_____	_____

10) Briefly describe (5-10 sentences) your experience as a parent/guardian of a child experiencing SED and/or co-occurring disorder in the early days of the diagnosis (only share what you are comfortable sharing).

Please include the name and contact information for three references:

1. _____

2. _____

3. _____

You may use this space for any additional information you would like to include.

My signature affirms that all of the information contained in this application is true and correct to the best of my knowledge and has been completed by no other person. I understand that knowingly providing false information will be grounds to deny or terminate my certification.

Applicant's signature _____ **Date** _____

If you have any questions or concerns, please contact Joanne Abbott at jabbott@namiindiana.org or call 317-925-9399 or 800-677-6442.

Return application to: NAMI Indiana
2601 Cold Spring Rd
Indianapolis, IN 46222

Fax to: NAMI IN, Attn. Joanne Abbott 317-925-9398
Email to: Joanne Abbott, jabbott@namiindiana.org