



**Division of
Mental Health
and Addiction**

Youth and Young Adult Peer Support Provider Application

Please complete the form below or use our online form: <http://bit.ly/2CYSP>

Please print:

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Email _____ **Phone(s)** _____

Date of Birth _____ **Estimated Date of Diagnosis** _____

All applicants will be expected to submit to the followings screenings after the training, as well as the passing of the Youth Peer 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 the eligibility requirements in order to participate in the Youth Peer Support Provider training program.

1. Have you been in recovery for a least 2 years ?
 Yes No
2. Do you meet the requirement of being 18 years of age or older?
 Yes No
3. Do you meet the requirement of having a valid Indiana driver’s license and reliable transportation?
 Yes No
4. Do you meet the requirement of having earned a high school diploma or GED?
 Yes No
5. Do you meet the requirement of having basic computer skills, including email and Microsoft Office?
 Yes No
6. Are you willing and able to attend a 40-hour training?
 Yes No
7. Are you currently or have you been diagnosed by a physician/psychologist with a serious mental illness (SMI), serious emotional disturbance (SED), and/or co-occurring disorder?
 Yes No Physicians name _____

8. Name of diagnosis(es)

9. Have you had at least two years' experience within the last eight years living with SMI, SED, and/or co-occurring disorder?

i. Yes No

Please list the systems you have navigated while living with SMI, SED, and/or co-occurring disorder (ex., school system, justice system, Wraparound, etc.):

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Please list your strengths. (If you cannot think of any, what would your friends/family say your strengths are?)

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Briefly describe (5 – 10 sentences) your experience in the early days of your diagnosis as a youth/young adult experiencing SMI, SED, and/or co-occurring disorder. Only share what you are comfortable sharing.

Briefly describe (5 – 10 sentences) your experience today as a youth/young adult experiencing SMI, SED, and/or co-occurring disorder. Have you become involved in your own wellness? Only share what you are comfortable sharing.

Briefly describe (5 – 10 sentences) why you would like to become an Indiana Certified Youth Peer Support Provider.

Please include the name and contact information for three references:

1. Name _____
Relation _____
Contact _____
2. Name _____
Relation _____
Contact _____
3. Name _____
Relation _____
Contact _____

Please 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.

Signature _____

Date _____

If you have any questions or concerns, please contact Joana Goff at jgoff@namiindiana.org, or call 1-800-677-6442.

Return Application to:

NAMI Indiana
921E 86th St, Suite 130
Indianapolis, IN 46260

Fax to:

NAMI Indiana
Attn. Joana Goff
317-925-9398

Email to:

Joana Goff
jgoff@namiindiana.org