# REGISTRATION FORM

## Kansas Certified Peer Specialist (KCPS) Level Two Training

**Location of Event**

**To be held virtually through Zoom. NOTE: Attendees must have internet access and use computer with video.**

**Dates**

**March 24-26, 2021**
**March 24th 9:00AM - 12:00PM**
**March 25th: 9:00AM - 4:00PM**
**March 26th: 9:00AM - 4:00PM**

**All three days must be completed to be eligible for exams and certification**

**Purpose:**

Develop and demonstrate required core competencies as a Certified Peer Specialist in the Kansas Behavioral health recovery workforce.

**Requirements:**

Persons applying to become a Kansas Certified Peer Specialist (KCPS) should be persons who identify as having a psychiatric diagnosis and have lived recovery experience with mental health disorders. This position in the Behavioral health recovery workforce enables individuals in recovery to serve as Kansas Certified Peer Specialists to those receiving services.

**To be eligible for Level Two training, the following is required:**

- Completion of the KDADS/BHS approved Level One (online) training with minimum of 80% passingon associated exam
- Employed as Kansas Certified Peer Specialist in Training
- Level 2 CPS Training Approval form (completed and signed by CPS Supervisor & returned to KDADS)
- Review and sign 1. Code of Ethics, 2. Merit of Public Trust, 3. Affirmation for All (these documents will need to be returned to KDADS prior to the training)

| | | | |
|---|---|---|---|
| **Your Name:** | | **Supervisor Name:** | |
| **Employer:** | | **Address:** | |
| **City/State:** | | **Zip:** | |
| **Your Email:** | | **Supervisor Email:** | |
| **Your Phone:** | | **Supervisor Phone:** | |

**Send registration documents by e-mail to carrie.a.billbe@ks.gov or by fax to Carrie Billbe, (785)-296-0256. NOTE: If you have a request for special accommodations that you will need to arrange for the training please contact Carrie Billbe at least one week prior to the training date by e-mail to carrie.a.billbe@ks.gov or by phone (785)296-3773.**

**State of Kansas, Behavioral Health Services is offering this training and certification at no charge to qualified applicants.**

Kansas
Department for Aging and Disability Services

# LEVEL 2 CPS TRAINING APPROVAL

(CPS SUPERVISORS MUST COMPLETE)

_____ has demonstrated competency in providing peer support services and is ready to attend and participate in the Level 2 CPS "in-person" training. This individual has worked as a peer support provider at _____as a Kansas Certified Peer Specialist in Training (KCPST) since _____.

Comments:

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_____ _____

Supervisor Name (printed) Phone number

_____ _____

Supervisor Signature Date

NOTE: Please return completed and signed form to:

KDADS
Behavioral Health Services/ Attention: Carrie Billbe
503 S. Kansas Avenue
Topeka, KS 66603-3404
(785) 296-3773
carrie.a.billbe@ks.gov

***State of Kansas***
***Certified Peer Specialist Code of Ethics***
*Approved by the Kansas Consumer Advisory Council for Adult Mental Health*

CPSs will maintain high standards of professional conduct and ethics as embodied in the statements below:

1. CPSs will be guided by the principles of self-determination for all. The primary responsibility of peer support is to help individuals achieve their own needs, wants and goals.
2. Certified Peer Specialists will maintain high standards of personal conduct. Certified Peer Specialists will also conduct themselves in a manner that fosters their own recovery.
3. CPSs will share with consumers and colleagues their recovery stories from mental illness and will likewise be able to identify and describe the supports that promote their own recovery.
4. CPSs will respect the privacy and confidentiality of those they serve.
5. CPSs will at all times respect the rights and dignity of those they serve.
6. CPSs will keep current with emerging knowledge relevant to recovery and share this knowledge with their colleagues and those they serve.
7. CPSs will never intimidate, threaten, harass, use undue influence, physical force or verbal abuse, or make unwarranted promises of benefits to the individuals they serve.
8. CPSs will never engage in exploitive and/or sexual/intimate activities with the persons they serve.
9. CPSs will not practice, condone, facilitate or collaborate in any form of discrimination on the basis of ethnicity, race, gender, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other preference or personal characteristic, condition or state.
10. CPSs will advocate for those they serve that they may make their own decisions in all matters, including when dealing with other professionals.
11. CSPs will advocate for the full integration of individuals into the communities of their choice and will promote the inherent value of these individuals to those communities. CPSs will be directed by the knowledge that all individuals have the right to live in the least restrictive and least intrusive environment.
12. CPSs will not enter into commitments that conflict with the interests of those they serve.
13. CPSs will not exchange gifts of significant monetary value with those they serve.

Applicant Signature _____ Date_____

Printed name of Applicant _____

# MERIT OF PUBLIC TRUST: ALL MUST COMPLETE

Please answer the following questions. Note: If the answer to any of the items 1 through 11 in this section is "Yes," submit as part of your application a signed, dated type-written explanation that gives specific details including disposition of the matter. A "yes" answer will not automatically exclude you from certification.

1. Have you ever been charged with or convicted of a felony or misdemeanor (including Driving Under the Influence convictions) other than a traffic violation? Yes ____ No____

2. Have you ever had a complaint filed with a professional association or a counselor certifying, licensing, or registering body against you for alleged unethical behavior or unprofessional conduct? Yes ____ No____

3. Have you used any alcohol, narcotic, barbiturate, other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years? Yes ____ No____

4. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including alcohol/drug addiction or dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years? Yes ____ No____

5. Have you gambled in a manner which would reflect adversely on the credibility and integrity of the profession in the past 2 years? Yes ___ No ___

6. Have you used controlled substances which were obtained illegally, or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years? Yes____ No____

7. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct, or any other grounds? Yes ____ No____

8. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes ____ No____

9. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit? Yes ____No____

10. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult?
Yes ____ No____

11. Have you ever been found guilty of or liable for fraud, deceit in connection with services rendered as a behavioral health provider by a civil or criminal court of law or board of a professional organization?
Yes ____ No____

*I certify the information provided here is true and correct. I understand that falsification can result in denial of application or revocation of certificate.

Applicant Signature _____ Date_____

Printed name of Applicant _____

**AFFIRMATION:** All must complete

I certify that I voluntarily make this application, and freely submit myself to the evaluation of the BHS Certification Review. I will accept the decision of the BHS Reviewers and do accept full responsibility for any and all consequences of the process of seeking certification. To the best of my knowledge, the information contained on this application is true and correct. I authorize members or representatives of the BHS Review Staff to contact and obtain information or opinions from any references, employers or educational institutions or agencies deemed necessary in evaluation of this application for certification. I have read the BHS Code of Ethics and understand its meaning. I further understand that any violation of the Code of Ethics may result in suspension or revocation of my certificate. I further understand that revocation of my state credential or license may result in suspension or revocation of my certificate. I understand I must notify BHS of any address or name change within 30 days of occurrence.

Do You Have One Year Of Stable Recovery? ___ YES ___ NO

_____ _____

Date Signature of Applicant

OPTIONAL:

I waive my right to inspect the results of any such inquiries made in references, employers, or educational institutions. I waive my right to inspect any letter of endorsement or competence evaluation.

_____ _____

Date Signature of Applicant