Peer Support

* = required field

I. Service Capacity

A. Identify which of the qualification categories applies to your provision of Peer Support:

Individual Certified Older Adult Peer Specialists (COAPS): * _____

Peer Support Provider Agency:* _____

For Agency Providers:

Do you contract with the Department of Mental Health to provide Peer Support?*

☐ N/A

_____

Specify the number of COAPS employed by your Agency.

☐ N/A

_____

B. Describe your service capacity throughout the State. Specify any areas that you do not provide Peer Support:

_____

C. Describe your capacity to provide translation for consumers when needed.*

Language	# Administrative Staff (if applicable)	# Certified Older Adult Peer Specialists (COAPS)	# Supporting Older Adults Remotely (SOAR)

If you have no translation capacity, describe your procedure for serving consumers who have limited English-speaking ability. *

☐ N/A

_____

D. Do you offer Peer Support for one peer providing support to another peer (i.e., the consumer) and in small groups?*

☐ N/A

_____

If applicable, describe your process when arranging Peer Support in small groups.*

☐ N/A

_____

II. General Policies and Procedures

A. Describe your policy for notifying the ASAP when a consumer is absent from one of the planned Peer Support activities/interactions (for example, consumer does not answer door or meet as planned) and for communicating when there is a possible barrier that affects the provision of Peer Support (for example, access to transportation).*

_____

I. Staff Qualifications

Describe how you ensure that individuals providing Peer Support have a Certificate of successful completion of Certified Older Adults Peer Specialist (COAPS) training. *

☐ N/A

_____

Attach a COAPS Certificate for each individual.*

☐ N/A

Attachment Name(s):

_____

IV. Training

A. For Agencies employing COAPS, describe your orientation. *

☐ N/A

_____

V. Supervision

A. For Agencies employing COAPS, describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors. *

☐ N/A

_____

VI. Proposed Rate Structure for Peer Support *

_____

Provider employee who completed this form*

Name: _____ Date: _____