Application Date: ____/____/____

Application to
10-Day Integrated Healthcare Recovery Support Specialist Institute

Training City:_____

Full Name: ***(please provide your name as it appears in the AHCCCS system)***

First: _____M.I.: _____

Last: _____

Date of Birth: ____/____/____

Contact Information:

Street Address: _____Apartment/Unit #: _____

City: _____State: _____ZIP: _____County: _____

Best Phone: (_____)_____-_____ ☐ Cell ☐ Home ☐ Message

Email: _____

No length of sobriety requirements, as recovery is self-directed.

Are you **employed?** ☐ **Yes** ☐ **No**

Do you have a High School Diploma or GED? ☐ **Yes** ☐ **No**

People who are employed or do not have a HS/GED are not eligible for the training.

Are you in the **Serious Mental Illness (SMI) Category**? ☐ **Yes** ☐ **No**

Are you in the **General Mental Health/Substance Abuse (GMH/SA) Category?** ☐ **Yes** ☐ **No**

Are you currently enrolled in **AHCCCS/Title XIX/Medicaid?** ☐ **Yes** ☐ **No**

Are you currently enrolled in **Medicare?** ☐ **Yes** ☐ **No**

What **behavioral health agency** are you currently a member of?

Name of Agency: _____County: _____

Recovery Coach: _____Phone: (_____)_____-_____

Email: _____Fax: (_____)_____-_____

How did you hear about the Workforce Development Program?

☐ Another Participant/Peer ☐ Recovery Coach ☐ Brochure ☐ Advertisement

What is the most important reason you are applying to the Workforce Development Program?

☐ To gain employment as a Peer ☐ To support my recovery ☐ To keep my health insurance

MARY ELLEN COPELAND'S
WRAP SEMINAR I (Developing your own WRAP)

The Wellness Recovery Action Plan® or WRAP® is a structured system for monitoring uncomfortable and distressing feeling and behaviors and, through planned responses, reducing, modifying or eliminating them. It also includes plans for responses from others when you cannot make decisions.

This 2-day workshop will allow you to work one on one with individuals in completing a WRAP and is the prerequisite to the 5-day facilitator training, which will allow you to co-facilitate WRAP groups independently.

WRAP is an optional 2-day training that needs to be added to your ISP. The frequency for the Institute and WRAP needs to be 1 to 3 times a week for 6 weeks.

Will you be attending WRAP? ☐ Yes ☐ No

Name: _____

Do you require **special accommodations** for training or employment? If yes, please indicate below:

_____

Documents Needed for Completed Application:

1. Completed Application.
2. Two Letters of Character Reference
3. One Page (100 typed words) "Why I Want to be an RSS?"
4. Completed Community Specialty Service Agency Packet. (*To be completed by agency*)

*I certify this information is true and correct, and I have **not** been certified in Peer Support by another agency.*

Signature: _____ Date: ___/___/___

☐ By checking this box and typing my name above, I am electronically signing my application.

Submit Application to:

Workforce Development Program

fcm-wdp@email.arizona.edu

Work: (520) 621-1642 • Fax: (520) 626-7833

Specialist Agency packet is required for the Workforce Development Institute.

Skills Training & Development (H2014-HQ) and
Peer Support (H0038-HQ) will be provided.