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1. **Personal Date**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/County/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Demographic Information**

Please answer the following optional demographics questions. We use this data for statistical and grant-reporting purposes only.

**Race/Ethnicity:** \_\_ African American \_\_ Latino/Hispanic \_\_Native American \_\_ Asian American \_\_Caucasian \_\_ Other

**Gender:** \_\_ Male \_\_ Female \_\_ Other \_\_ Prefer Not to Say

**Age:** \_\_ 18-30 \_\_ 31-45 \_\_ 46-60 \_\_ 60+

1. **Education Record**
2. What is your highest level of education?

\_\_High School \_\_Some college \_\_Bachelor’s degree \_\_Master’s degree

\_\_Doctorate \_\_Other (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Supporting documents required:* Please submit a copy of your GED, high school diploma, or higher-level education diploma or transcript.

**VI. Recovery Questions**

1. What is your primary area of recovery? \_\_Substance Us \_\_Mental Health \_\_Co-Occurring
2. Do you currently take Suboxone, Subutex, or Methadone? \_\_Yes \_\_No
3. Recovery Statement: briefly describe your lived experience and recover journey.
4. What does recovery mean to you?
5. How are you maintaining your recovery today? How do you plan o maintain it in the future?

**VII. Peer Support Questions**

1. Why do you want to become a Peer Support Specialist?
2. List some of your skills or areas of expertise:
3. Why do you think its important to share your recovery story as a Peer Support Specialist?
4. Do you have any experience as a Peer Support Specialist? \_\_Yes (explain) \_\_No
5. Describe the ways you have been active in your community in the past six months. Please highlight roles that would aid in your work as a Peer Support Specialist. *Do not include things that you do to maintain your personal recovery.*

**X. Candidate’s Confirmation of Recovery**

*“I attest that I have a minimum of two (2) consecutive years from substance use and/or mental health disorder.”*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_

*“I attest that I have maintained a minimum of two (2) consecutive years of abstinence from illicit drugs and alcohol.”*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_/\_\_/\_\_

**XI. Arkansas Peer Recovery Code of Ethics**

All current and potential candidates for the Arkansas Peer Support Specialist Program are required to adhere to the Arkansas Code of Ethics. Ethics code violations may result in the disciplinary actions, including loss of your credential.

*“I attest that I have read, understand, ad will adhere to the Arkansas Peer Recovery Code of Ethics.”*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_

**XII. Candidate’s Affirmation**

*“I certify that I meet the eligibility requirements for the Arkansas Department of Human Service’s Peer Support Specialist Program (APSP), and the information in this application and it’s supporting documents is accurate, correct, and complete. I also certify that I do not hold a credential, license or certification that is or has been subject to criminal or ethical complaint. The APSP is authorized to contact any institution, organization, or individual listed on or included with this application for verification of the information provided this includes sharing this application and supporting documents with the Arkansas Peer Advisory Committee. I understand that APSP retains ownership of the application and may from the time to time, make available names and other information to potential service uses.”*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_/\_\_/\_\_

Please return this application to the Michael Little at Michael Little Michael.L.Little@dhs.arkansas.gov