**Peer Support**

1. **Service Capacity**
2. 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?

Specify the number of COAPS employed by your Agency.

1. Describe your service capacity throughout the State. Specify any areas that you do not provide Peer Support:
2. Describe your capacity to provide translation for consumers when needed.

|  |  |  |
| --- | --- | --- |
| Language | # Administrative Staff (if applicable) | # Certified Older Adult Peer Specialists (COAPS) |
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|  |  |  |
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If you have no translation capacity, describe your procedure for serving consumers who have limited

English-speaking ability.

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

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

**II. General Policies and Procedures**

1. 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).

**III. Staff Qualifications**

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

Attach a COAPS Certificate for each individual.

**IV. Training**

1. For Agencies employing COAPS, describe your orientation.

**V. Supervision**

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

**VI. Proposed Rate Structure for Peer Support**

Provider employee who completed this form

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

**Peer Support**

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On-Site Evaluation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| EMPLOYEE Record Review | | | | | |
| Provider  Date  Monitor |  |  |  |  |  |
| Start date  and Termination date, if applicable |  |  |  |  |  |
| Number of reference checks |  |  |  |  |  |
| CORI Check |  |  |  |  |  |
| Job Description(s) |  |  |  |  |  |
| COAPS Training Certificate  Ongoing training: dates (if applicable): |  |  |  |  |  |
| OIG checks: time of hire/ monthly |  |  |  |  |  |
| Annual Performance Appraisal: Date |  |  |  |  |  |
| Comments | | | | | |

**Peer Support**

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On-Site Evaluation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| CONSUMER Record Review | | | | | |
| Provider  Date  Monitor |  |  |  |  |  |
| Authorization/referral form |  |  |  |  |  |
| ID Info – name; address; phone; DOB |  |  |  |  |  |
| Emergency contact(s) and phone |  |  |  |  |  |
| Functional status/limitations  Activities/Interactions: Dates |  |  |  |  |  |
| Name of current CM/RN |  |  |  |  |  |
| Service start date  and Termination date, if applicable |  |  |  |  |  |
| Comments |  |  |  |  |  |

**Peer Support**

**Notes**