MONTANA BOARD OF BEHAVIORAL HEALTH
PO BOX 200513 (301 S. Park Ave, 4th Floor)
Helena, MT 59620-0513
Licensing Phone Number: 406-444-5773
E-Mail: dlibsdbbh@mt.gov **Website:** www.bbh.mt.gov

CERTIFIED BEHAVIORAL HEALTH PEER SUPPORT SPECIALIST

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TERMS & DEFINITIONS

Below you will find a list of terms and definitions pertinent to the Peer Support Specialist Credential. Our goal is to provide useful information for you as you make application for the certificate. The application instructions begin on the page following the definitions.

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CBHPSS: Certified Behavioral Health Peer Support Specialist
BHPSS: Behavioral Health Peer Support Specialist, (pre-certification)

MCA 37-38-102, Definitions. As used in this chapter, the following definitions apply:
(1) "Behavioral health" includes a person with a diagnosis of:
(a) a mental disorder, as that term is defined in 53-21-102; or
(b) chemical dependency, as that term is defined in 53-24-103.
(2) "Behavioral health peer support" means the use of a peer support specialist's personal experience with a behavioral health disorder to provide support, mentoring, guidance, and advocacy and to offer hope to individuals with behavioral health disorders.
(3) "Board" means the board of behavioral health established under 2-15-1744.
(4) "Certified behavioral health peer support specialist" means a person who:
(a) has experienced and is in recovery from a behavioral health disorder;
(b) has obtained the education and skills needed to provide therapeutic support to individuals with behavioral health disorders; and
(c) possesses a valid and current certification.
(5) "Mental health professional" means:
(a) a physician licensed under Title 37, chapter 3;
(b) a psychologist licensed under Title 37, chapter 17;
(c) a social worker licensed under Title 37, chapter 22;
(d) a professional counselor licensed under Title 37, chapter 23;
(e) an advanced practice registered nurse, as provided for in 37-8-202, with a clinical specialty in psychiatric mental health nursing;
(f) a marriage and family therapist licensed under Title 37, chapter 37; or
(g) a licensed addiction counselor licensed under Title 37, chapter 35.

24.219.901 ARM, DEFINITIONS (1) "Behavioral health disorder" means a wide range of mental health conditions or disorders that affect mood, thinking, and behavior that impair the individual's ability to build or maintain satisfactory interpersonal relationships and to manage daily functioning.
(2) "Behavioral health disorder recovery" or "recovery from a behavioral health disorder" means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
(3) "CBHPSS" means a certified behavioral health peer support specialist.
(4) "Exploitation" means the manipulation or use, or the attempted manipulation or use, of a professional relationship with a client for a CBHPSS's emotional, financial, romantic, sexual, or personal advantage, or for the advancement of the CBHPSS's personal, religious, political, or business interests.
(5) "Sexual contact" includes but is not limited to sexual intercourse, either genital or anal, cunnilingus, fellatio, or the handling of the breasts, genital areas, buttocks, or thighs, whether clothed or unclothed.
(6) "Supervision plan" means a plan, in a form approved by the board that describes the type, structure, and amount of supervision that a CBHPSS must have to satisfy the requirements for the certification.
(7) "Supervisor," when used to refer to a person who supervises the work of a CBHPSS, means a person who meets the criteria set forth in ARM 24.219.902.

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Department of Public Health & Human Services, DPHHS, Statute

MCA § 53-21--102. Definitions. As used in this chapter, the following definitions apply:

(9) (a) "Mental disorder" means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions. A mental disorder may co-occur with addiction or chemical dependency.

MCA § 53-24-103. Definitions. For purposes of this chapter, the following definitions

(4) "Chemical dependency" means the use of any chemical substance, legal or illegal, that creates behavioral or health problems, or both, resulting in operational impairment. This term includes alcoholism, drug dependency, or both, that endanger the health, interpersonal relationships, or economic functions of an individual or the public health, welfare, or safety.

(13) "Treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation, and career counseling, which may be extended to chemically dependent persons, intoxicated persons, and family members.

Peer Support Supervision Rules

◇ ARM **24.219.902 Supervisor Qualifications:**

(1) An individual supervising post-certification employment of a CBHPSS shall have the minimum qualifications set forth in this rule. The supervisor must be a physician licensed under Title 37, chapter 3, MCA; a psychologist licensed under Title 37, chapter 17, MCA; a social worker licensed under Title 37, chapter 22, MCA; a professional counselor licensed under Title 37, chapter 23, MCA; an advanced practice registered nurse, as provided for in 37-8-202, MCA, with a clinical specialty in psychiatric mental health nursing; a marriage and family therapist licensed under Title 37, chapter 37, MCA; or a licensed addiction counselor licensed under Title 37, chapter 35, MCA.

(2) The supervisor must hold an active and current license in good standing, issued by the licensing board or other officially recognized licensing body.

(3) The supervisor must have:

(a) three years of licensed experience working in the supervisor's respective discipline; or

(b) board-approved training in clinical supervision, which shall consist of a minimum of one semester credit of post-licensure board-approved graduate education; or 20 clock hours of board-approved training in clinical supervision.

◇ ARM **24.219.916, Supervision Requirements:**

(1) To meeting the ongoing supervision requirement in 37-38-202, MCA, a CBHPSS shall comply with the supervision guidelines as follows:

(a) A supervisor must meet the requirements of ARM 24.219.902.

(b) A supervision agreement shall be in writing and on a form available on the board web site. The agreement shall include, but is not limited to:

(i) the CBHPSS's and supervisor's names, signatures, and dates of supervision;

(ii) the duties and obligations of the CBHPSS and supervisor per this rule, frequency and method of supervision, and duration and termination provisions; and

(iii) a statement of compliance with applicable patient privacy laws.

(c) The supervisor's relationship with the CBHPSS shall not be a conflict of interest, such as, but not limited to, being in a cohabitation or financially dependent relationship.

(d) The supervisor shall not be the certificate holder's parent, child, spouse, or sibling.

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(2) A record of supervision must be maintained by the CBHPSS and must include:

(a) names of the CBHPSS and supervisor, and signatures of both;

(b) date and length of supervision in increments of not less than 15 minutes;

(c) content that confirms that the CBHPSS has received a minimum of one hour of face-to-face supervision and consultation for every 20 hours of work experience. No more than 40 hours of work experience may transpire without receiving the required hours of supervision and/or consultation. Less frequent supervision may take place only with prior approval of the licensure board;

(d) content summary (excluding confidential information); and

(e) content demonstrating the CBHPSS's ongoing competence. Supervisory comments must indicate ongoing competence and any areas in need of improvement.

(3) The supervisor must attest to (1)(b) through (d) and (2)(a) through (e) under penalty of law. Falsification or misrepresentation of any of the above may be considered misrepresentation and a violation of professional ethics, which may result in discipline of the certificate holder or supervisor's license.

(4) All reports, written interpretations, and results sent to other public or private agencies that affect the current status of a client must be reviewed by and contain the approval and signature of the supervisor.

(5) All interventions, results, and interpretations used in the planning and/or implementation of interventions shall be reviewed and preapproved by the supervisor on a continual and ongoing basis.

(6) All professional communications, both private and public, including advertisements, shall clearly indicate the certification status as a CBHPSS.

(7) Upon a change of supervisor:

(a) the CBHPSS must notify the board prior to beginning work; and

(b) the CBHPSS's previous supervisor must provide the record of supervision to the board.

(8) For any other substantial change in the CBHPSS's supervision plan, the CBHPSS must notify the board within ten business days.

(9) The CBHPSS and supervisor are responsible for ensuring that the CBHPSS and supervisor comply with the requirements of this rule and the statutes, rules, and standards pertaining to the practice of a CBHPSS.

(10) The CBHPSS must maintain the record of supervision, which must be maintained according to the requirements of this rule for a minimum of seven years and may be requested by the board at any time.

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INSTRUCTIONS FOR CERTIFICATION AS A BEHAVIORAL HEALTH PEER SUPPORT SPECIALIST (CBHPSS)

Complete the application or apply for certification on-line at https://ebiz.mt.gov/pol. The on-line application fee may be paid by debit or credit card. Your on-line account allows you to make changes to your application and upload application documents to your record. **PLEASE SAVE AND SECURE YOUR USER NAME AND PASSWORD AS YOU WILL USE IT OFTEN THROUGHOUT YOUR CAREER** for accessing your record and always at renewal time.

- **FEES:**
  - Peer Support Specialist licensure fee is $125.00. Please enclose your payment with your application.
  - Fees are payable to the Montana Broad of Behavioral Health by check, money order or cashier's check.
  - All application fees are NON-REFUNDABLE and must be received with your application to insure proper processing.
  - Submission of fees and an application does not ensure issuance of a certificate.

- **VERIFICATION OF CERTIFICATION OR LICENSURE:**
  - The applicant is responsible for requesting official verification from each state for each peer support licensure or certification and ALL professional licenses, regardless of that license status.
  - Photo copies of licenses do not qualify as official verification and should not be included with your application.

- **FINGERPRINT/BACKGROUND CHECK PROCESS:**
  - For best results, you are encouraged to have your finger prints taken at a facility that does digital prints.
  - **The processing of fingerprint and background check may be lengthy with the Department of Justice, more than 6 weeks. For this reason, you are encouraged to complete your paperwork for that process ASAP.**
  - Read, attest to reading, and sign the Noncriminal Justice Applicant's Rights form (the form is included in this application).
  - Fingerprint cards are available from most local law enforcement agencies and the Montana Department of Justice (DOJ). Complete the information requested at the top of the fingerprint card prior to having your prints taken and include the following information:

EMPLOYER & ADDRESS:	Board of Behavioral Health PO Box 200513, Helena, MT 59620-0513
REASON FINGERPRINTED:	Licensure & MCA 37.38.202
ORI Number:	MT 920095Z

  - Most local law enforcement agencies will take your fingerprints for a nominal fee. After paying this fee and having your fingerprints taken, **send the completed fingerprint card along with a check or money order for $27.25 made payable to the Montana Department of Justice and mail it to Montana Criminal Records, 2225 11th Avenue, PO Box 201403, Helena, MT 59620-**

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1403. Please check with your local post office and add accurate postage prior to mailing.

- ❖ If DOJ rejects your first prints as "unreadable", the Board office will notify you and you will need to re-submit your fingerprints. You are not required to repay the processing fee to the Montana Department of Justice under these circumstances.
- ❖ **Criminal History Record Information (CHRI) from the fingerprints is only released to the Board of Behavioral Health. Your application will not be considered complete until the CHRI is received from the DOJ.**

◇ **REQUIRED DOCUMENTATION:** The following documents must be received by the Board office to complete your certification application. All forms are available on the Board website at http://boards.bsd.dli.mt.gov/bbh#9

- ❖ The completed application form and the application fee.
- ❖ A forty (40) hour peer support education program completed in the past 5 years.
  - o The program must address 18 core competence domains.
  - o If the education is completed at a college or university, a transcript must be sent from the school directly to the Board office.
  - o If the education is completed in a training setting, the trainer must provide a certificate of completion sent directly to the Board office.
  - o An exam must be part of the education/training event. Exam results must be sent directly to the Board office from the school or the trainer.
  - o If an exam was not included with the training event, an applicant may pursue completion of an exam from an alternative Board approved education provider.
  - o Approved education, training events, and exams are posted to the website, www.bbh.mt.gov under the education tab.
- ❖ The supervision form includes the Supervisor Agreement/Supervision Plan. Both must be signed by the applicant and an approvable supervisor according to MCA 37.38.201(5)(a-e). Applicants may have more than one supervisor. Certificate holders and Supervisors must notify the Board when a supervisor change occurs. A Supervisor Agreement/Supervision Plan must be completed for the certification application and for EACH SUPERVISOR post-certification and PRIOR to commencing supervision with that supervisor. A Supervisor Termination Summary must be received at the Board office within ten days of the change in a Supervisor. All supervision forms are included with this application and are also posted on the BBH website.
- ❖ **Behavioral Health Disorder Diagnosis confirmation**. Peer Support Specialist certification requires a behavioral health disorder diagnosis. Applicants are required to provide attestation of their diagnosis with their application.
- ❖ A Behavioral Health Disorder Recovery Guideline is included with this application and is posted on the website. The applicant must provide a narrative that outlines the recovery program from the behavior health disorder. Though your work as a CBHPSS is vital, do not include it a component of your recovery. Strong recovery elements make your ability to work possible. Please be clear on this. The recovery narrative must accompany the application.
- ❖ Applicants must contact other states/providences of licensure or certification and request verification of all past and current licenses or certifications. Verifications must be sent directly to the Board office from the other states or jurisdictions. Photocopies of licenses do not qualify as official verification and should not be

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included with your application. The Applicant is responsible for paying any fees that are required.
- All documents not in English must be accompanied by certified translations.

◇ NON-ROUTINE APPLICATIONS:

- If an application is deemed non-routine, there may be a delay in processing.
- It is critical to your certification to not withhold any information regarding each question on the application.
- Questions 12-29 may contribute to a non-routine application status. To reduce delays in processing your application please attach a detailed explanation and provide supporting documentation from the source. Scanning and uploading documents to your record or sending the materials by email to staff is most efficient. The **Legal and Health History Content Form** is attached to this application and is designed as a guide.
- Thoroughly respond to the items on the **Legal and Health History Content Form** and submit all documents with your application.
- You will be notified by e-mail of any deficiencies in their application. **ALWAYS MAINTAIN YOUR CURRENT CONTACT INFORMATION WITH THE BOARD OFFICE.**
- The Board may request that you provide additional information and you may be requested to be available in person or by phone for a scheduled Board meeting.
- A complete application must be received by the Board 20 business days prior to a scheduled board meeting. Please refer to our website for Board meeting dates.

◇ POST CERTIFICATION SUPERVISION:

- Supervision by a mental health professional according to MCA 37.38.102(5) is required throughout your career as a CBHPSS in Montana.
- A Supervisor Agreement & the Supervision Plan are included and is required for certification. Further, you must notify the Board within 10 days if/when there are any substantial changes to the Supervision Plan
- Prior to changing supervisors, you must notify the Board office.
- You and your former Supervisor must provide the Supervision Logs to the Board and the Supervisor must submit a Supervision Termination Summary report to the Board office.
- **A new Supervisor Agreement/Supervision Plan must be submitted and approved by the Board office prior to commencing work under a new Supervisor**.
- The CBHPSS is responsible for the maintenance of the supervision logs according to the administrative rules. The records must be maintained for a period of 7 years and may be requested by the Board at any time.

◇ RENEWAL:

- All CBHPSS certificates expire on December 31 each year.
- Renewal notices are mailed 45 days prior to the expiration date to your address of record. A change of address form is available at www.bbh.mt.gov under the Forms tab. **ALWAYS KEEP ALL CONTACT INFORMATION CURRENT WITH THE BOARD OFFICE.**
- All CBHPSS certified in Montana must maintain proof of 20 continuing education credits, earned from January 1- December 31st, i.e. certificates of completion.

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- First time CBHPSS certified before July 1 of the renewal year will be required to fulfill the 20-hour requirement. Those certified July 1 through October 1 are required to obtain 10 hours of continuing education. Those certified after October 1 will not be required to obtain continuing education credits for renewal. THIS APPLIES TO FIRST YEAR RENEWAL ONLY.
- All CBHPSS must submit affirmation of compliance to the Board on each years' CERTIFICATION renewal that they understand their duty to comply with the continuing education requirements for maintaining their certificate.
- Certificate holders have the option of placing their certificate on Inactive Status. Check the website under Regulations for additional information.

◇ CERTIFICATION OF OUT-OF-STATE APPLICANTS:

- Out of State applicants must meet all requirements of Montana certification.
- Complete the application or apply for certification on-line at https://ebiz.mt.gov/pol. The on-line application fee may be paid by debit or credit card.
- Complete all processes, submit all required documents and pay the fee.
- Applicants must contact other states/providences of licensure or certification (past and current) and request verification of current license or certification status. Photocopies of licenses do not qualify as official verification and should not be included with your application. The Applicant is responsible for paying any fees that are required.

◇ IMPORTANT INFORMATION FOR ALL APPLICANTS:

- It is the responsibility of the applicant AND THE CERTIFICATE HOLDER to keep the Board office informed of any name changes, address changes, changes in licensure status, complaints or proposed disciplinary action against you in this or any other state. The change of address form is available at www.bbh.mt.gov, under the Forms tab.
- The Board office most often uses E-mail to communicate with certificate holders. DO NOT MISS IMPORTANT INFORMATION FROM THIS OFFICE REGARDING YOUR CERTIFICATE because of an outdated E-mail address. **ALWAYS KEEP YOUR E-MAIL ADDRESS CURRENT WITH THE BOARD OFFICE.**
- The practice of Certified Behavioral Health Peer Support Specialists in Montana is governed by the Board's Statutes and Administrative Rules. These are found at www.bbh.mt.gov, under the Regulations tab.

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED. Application fees must be paid before your application can be reviewed.
When the Board has all necessary documentation, your application will be processed.
Incomplete applications expire 12 months from the date received by the Board of Behavioral Health.

THIS IS AN INFORMATION SUMMARY SHEET ONLY. THE APPLICANT IS RESPONSIBLE FOR READING THE COMPLETE MONTANA LAWS AND RULES FOR CERTIFICATION AS A CERTIFIED BEHAVIOR HEALTH PEER SUPPORT SPECIALIST PRIOR TO MAKING APPLICATION.
VIST OUR WEBSITE AT: www.bbh.mt.gov.

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For information about the processing of this application or other concerns, please contact the Board of Behavioral Health staff at 406-444-5773 or email us at dlibsdbbh@mt.gov.

PEER SUPPORT SPECIALISTS ARE NOT PERMITTED TO PRACTICE IN MONTANA WITHOUT AN ACTIVE MONTANA CERTIFICATE.
Full Certification Application Follows.

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PEER SUPPORT CERTIFICATION APPLICATION FEE – $125.00

Allow 30 business days from the date the Board office has received all required documentation for processing a routine application.

PLEASE PRINT OR TYPE

1. FULL NAME: ____
   Last First Middle

2. OTHER NAME(S) KNOWN BY: ______________________________________

3. BUSINESS NAME: ____

4. BUSINESS ADDRESS: ____
   Street or PO Box # City and State Zip

5. HOME ADDRESS: ____
   Street or PO Box # City and State Zip
   PREFERRED MAILING ADDRESS
   BUSINESS: ____________ HOME: ____________ EMAIL ADDRESS: ____________

6. BUSINESS PHONE: ____________________ HOME: ____________________

7. SOCIAL SECURITY NUMBER: ____________________ FOREIGN ID NUMBER: ____________________

8. DATE OF BIRTH: ____________ PLACE OF BIRTH: ____________ MALE FEMALE

9. LICENSE NAME: ____
   (State your name as it should appear on the license if granted.)

10. List ALL professional licenses or certificates you hold or have **ever** held. Verification must be sent directly to Montana from each state/province/territory. Failure to list any past Peer Support Specialist license or certification constitutes a falsification of your application and may result in a denial of your application and/or disciplinary action. **Please type or print legibly.**

State	License/Certification #	Issue Date	Expiration Date	Requested State Verification
				Yes No
				Yes No
				Yes No
				Yes No

11. I acknowledge that I have read the Non-Criminal Applicant's Rights Form and by answering yes, I acknowledge this agency has informed me of my privacy rights for fingerprint-based background check requests used by the agency for noncriminal justice purposes. Yes No

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12. Have you ever had an application for a professional or occupational license or certification refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

13. Have you ever withdrawn an application for licensure or certification prior to a licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

14. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license/certificate you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. Yes No

15. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupation license or certificate in anticipation of or during an investigation or disciplinary proceeding or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

16. Is there a pending complaint against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

17. Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. Yes No

18. Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years and that resulted in fine of less than $200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. Yes No

19. I attest that I have been diagnosed with a mental disorder as defined in MCA § 53-21-102(9) and/or a chemical dependency as defined in MCA § 53-24-103(4). Please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. Yes No

20. I attest that I am engaged in behavioral health disorder recovery that does not include any period of incarceration, or hospitalization or any inpatient admission related to a behavioral health disorder that exceeds 72 hours, within the two years immediately preceding application. Yes No
Please submit a description in your own words of your recovery program. See the **Behavioral Health Recovery Guideline** contained in this application.

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21. Within the past 5 years, have you any physical or mental health condition(s), other than as answered in question 19, which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving risk to the public? If yes, attach a detailed explanation. Yes No

22. Have you ever been court-martialed or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation from the source. Yes No

23. Have you ever been denied the privilege of taking an examination required for any professional or occupational license or certificate? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

24. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

25. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc.)? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

26. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

27. Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. Yes No

28. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. Yes No

29. Do you have any initiated or completed action against you by any State, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc.) If yes, please attach a detailed explanation and provide documentation from the source. Yes No

30. I hereby attest that I will continually abide by the professional and ethical requirements indicated in the Code of Ethics as defined at ARM 24.219.925 for Certified Behavior Health Peer Support Specialists. Yes No

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31. **Academic Degrees Received**: Include standalone certificates and certificates equivalent to a degree. For example, an AA degree in Human Service with a certification in Peer Support Specialist Services. List latest degree first. **Please type or print legibly.**

Degree Earned	Date Received	Institution	Major	Minor(s) or Certificate(s)	Peer Support Exam Taken	Score P/F?

32. **Conference or training event hours earned towards Peer Support Specialist education**. For hours to count towards certification, they must be approved by the Montana Board of Behavioral Health. Forty (40) hours in 18 core competence areas are required. **Please type or print legibly.**

Program Title	Program Trainer	Location	Dates	Hours Earned	Peer Support Exam Completed	Score P/F?

Upon completion of the training, the participant training certificate of completion and the training exam must be sent directly to the Board office by the Program Trainer.

33. Exam taken as part of a(n):
Academic Program:___________ Conference/Training Program: _________ Other: _____________

If other, please specify: ____

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BEHAVIORAL HEALTH PEER SUPPORT SPECIALISTS
Supervision Forms

The Supervision Agreement/Supervision Plan, is required for initial certification and anytime a new Supervisor assumes supervision duties of a CBHPSS. Please review all supervision rules located within this application. The Supervision Termination Summary is completed by the Supervisor and filed with the Board office when a CBHPSS discontinues services under a Supervisor.

A Supervision Agreement/Supervision Plan must be completed for EACH SUPERVISOR PRIOR to commencing supervision with that Supervisor. Certificate holders may have more than one Supervisor. Submit this form with the Candidate application to the Board of Behavioral Health at 301 South Park, 4th Floor, P.O. Box 200513, Helena, MT 59620-0513 or it may be uploaded to your on-line license record. If you don't have an account, one can be created at https://ebiz.mt.gov/pol/default.aspx.

A Supervisor Termination Summary must be received at the Board office when supervision services cease. All Supervision forms are included with the application and posted on the Montana Board of Behavioral Health website.

SUPERVISION AGREEMENT, (Make additional copies as needed)

It is the understanding of the Board of Behavioral Health of the State of Montana that

____
Supervisee's Name and Credential, if available

____
Address City ST Zip Code

____
Cell phone Work Phone E-Mail Address

will be a post-certification supervisee as a Certified Behavioral Health Peer Support Specialist at

____
Facility or agency

____
Address City ST Zip Code Phone number

under the ongoing supervision of

____
Supervisor's Name and Credential

____
Address City ST Zip Code

____
Cell phone Work Phone E-Mail Address

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SUPERVISION PLAN, (Make additional copies as needed)

The Supervisor and the Supervisee assume professional responsibility for compliance with the ongoing supervision requirements and for the statutes and rules pertaining to the practice of CBHPSS. This statement constitutes the written agreement of ARMs 24.219.902 & 24.219.916.

Duties and obligations of the CBHPSS:______________________________

____
____
____
____

Duties and obligations of the Supervisor:______________________________

____
____
____
____

Frequency of supervision: ______________________________

____
____
____
____

Duration of supervision: ______________________________

____
____

Method of supervision: ______________________________

____
____
____
____

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Termination provision:____

____

____

____

____

ATTESTATION

The Certified Behavioral Health Peer Support Specialist, CBHPSS and Supervisor(s) have read, understand, and acknowledge the requirements of the Supervision Forms. All have been approved by the CBHPSS and the Supervisor.
In signing below, the CBHPSS and the Supervisor attest to the terms of the agreement, compliance, with applicable patient privacy laws, confirmation that the qualifications of the supervisor are in accordance with current statute and administrative rule, and confirmation that it's understand that the CBHPSS and Supervisor are responsible for ensuring compliance with the requirements of their profession always.

Upon termination of the Supervision Agreement/Supervision Plan, the Supervisor shall provide a written Supervision Termination Summary of the clinical supervision experience highlighting performance in each of the 18 core competences and identification of any areas in need of improvement. The summary, along with a copy of the Supervision Logs must be submitted to the Board office prior to the CBHPSS commencing work under a new Supervisor.

Supervisor (Print name and license):____

Supervisor (Signature): ____
Date

Supervisee (Print name and license):____

Supervisee (Signature):____
Date

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Supervision Termination Summary

The following information must be completed by the Supervisor and submitted to the Board office upon termination of all supervisory relationship. Further, the CBHPSS should maintain this record with the clinical supervision logs.

If supervision occurred in more than one site, please include the information on a separate sheet.

1. ____
Name and CBHPSS Certificate Number

____
Address City St Zip

____
Cell Phone number Work Phone Number E-mail Address

2. ____
Facility or agency

____
Address City St Zip

____
Cell Phone number Work Phone Number E-mail Address

3. ____
Supervisor's name, Credential Supervisor Eligibility Date, (3 years post licensure) or

____
Provide certificate of completion for the approved supervision training & date of completion

____
Supervisor's Address City St Zip

____
Cell Phone number Work Phone Number E-mail Address

CBHPSS are required to receive a minimum of one hour of face-to-face supervision and consultation for every 20 hours of work experience. No more than 40 hours of work experience may transpire without receiving the required hours of supervision and/or consultation. Less frequent supervision may take place only with prior approval of the licensure board.

The Supervision Log must confirm that the CBHPSS has had contact with the Supervisor and the content (excluding confidential information) of the contact is summarized and demonstrates the CBHPSS's ongoing competence. Supervisory comments must indicate ongoing competence and any areas in need of improvement.

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The following information should coincide with the Supervision Log used for documenting contact and content.

4. Dates of Supervision: From: ______________________ To: ______________________
Mo Day Yr. Mo Day Yr.

5. Total number of hours of clinical supervision and consultation received by the CBHPSS? __________

6. Number of hours per week of face-to-face supervision. ______________________

7. Was group supervision and consultation provided? ______________________

8. If so how many hours were provided? ______________________

9. Substance Abuse and Mental Health Administration Core Competencies
CBHPSS must demonstrate minimum competence in the areas listed below.

Circle choices as follows:

1-2 = Does not meet minimal competency,

3-4 = Minimal competency met in this area.

5 = Above minimum competence in this area.

Please provide comments for any section receiving a One (1) or Two (2).

1. Boundaries and Ethics

1 2 3 4 5 ____

____

____

____

____

2. Confidentiality

1 2 3 4 5 ____

____

____

____

____

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3. **Scope of Practice**

1 2 3 4 5 ______________________________

____

____

____

4. **Communication Skills**

1 2 3 4 5 ______________________________

____

____

____

5. **Self-Care**

1 2 3 4 5 ______________________________

____

____

____

6. **Suicide Awareness**

1 2 3 4 5 ______________________________

____

____

____

7. **Stages of Change**

1 2 3 4 5 ______________________________

____

____

____

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8. **Trauma-Informed Care**

1 2 3 4 5 ____

____

____

____

9. **Cultural Awareness;**

1 2 3 4 5 ____

____

____

____

10. **Pathways of Recovery**

1 2 3 4 5 ____

____

____

____

11. **Recovery Story**

1 2 3 4 5 ____

____

____

____

12. **Clinical Supervision**

1 2 3 4 5 ____

____

____

____

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13. **Accessing Community Resources**

1 2 3 4 5 ____

____

____

____

14. **Emotional Intelligence**

1 2 3 4 5 ____

____

____

____

15. **Supporting Others in Recovery**

1 2 3 4 5 ____

____

____

____

16. **One-On-One Session Skills**

1 2 3 4 5 ____

____

____

____

17. **Support Group Facilitation**

1 2 3 4 5 ____

____

____

____

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18. Recovery Planning

1 2 3 4 5 ______________________________

____

____

____

10. Do you approve this CBHPSS to practice under a new qualified Supervisor according to ARM 24.219.902. If not, please clarify. Yes No

____

____

____

____

11. Additional Comments:

____

____

____

____

DECLARATION BY SUPERVISOR & CERTIFIED BEHAVIORAL HEALTH PEER SUPPORT SPECIALIST

As a Supervisor, in my opinion, the preceding is true and correct. I understand that by submission of this form to the Board of Behavioral Health, the post-certification supervision has ended. Future practice by the CBHPPS must be done under a new qualified supervisor. The CBHPSS must submit a Supervision Packet that includes the Supervision Contract and Supervision Plan for the new Supervisor(s). Without prior Board approval of a new Supervisor, the CBHPSS is subject to discipline by the Board.

Supervisor (Print name and license number):______________________________

Supervisor (Signature): ______________________________
Date

CBHPSS (Print name and certification number):______________________________

CBHPSS (Signature):______________________________
Date

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Certified Peer Support Specialist Code of Ethics

ARM 24.219.925 (1) Pursuant to 37-1-319 and 37-22-201, MCA, the board adopts the following professional and ethical standards for CBHPSSs to ensure their ethical, qualified, and professional practice for the protection of the general public. These standards supplement current applicable statutes and rules of the board. A violation of the following is considered unprofessional conduct as set forth elsewhere in rule, and may subject the CBHPSS to such penalties and sanctions provided in 37-1-136, MCA.

(2) All CBHPSSs shall:

(a) act in a way that encourages and promotes recovery for themselves and those they serve without placing judgment on the recovery path of others;
(b) share their own recovery story in a manner that promotes recovery, instills hope, and is a benefit to those they are serving;
(c) always use first person or recovery language and encourage this practice in others;
(d) engage in resolving concerns in a respectful and professional manner;
(e) maintain high standards of personal and professional conduct, always acting in a way that represents peer support in a positive and beneficial light;
(f) act as a positive role model in recovery;
(g) conduct themselves in a way that fosters their own recovery. CBHPSSs shall take personal responsibility to seek support and manage their wellness;
(h) provide clients with accurate and complete information regarding the extent and nature of the services available to them;
(i) terminate services and professional relationships with clients when such services and relationships are no longer required or where a conflict of interest exists;
(j) make every effort to keep scheduled appointments;
(k) notify clients promptly and seek the transfer, referral, or continuation of services pursuant to the client's needs and preferences if termination or interruption of services is anticipated;
(l) attempt to make appropriate referrals pursuant to the client's needs;
(m) obtain informed written consent of the client or the client's legal guardian and supervisor approval prior to the client's involvement in any research project of the CBHPSS that might identify the client or place the client at risk;
(n) obtain informed written consent of the client or the client's legal guardian and supervisor approval prior to taping, recording, or permitting third-party observation of the client's activities that might identify the client or place the client at risk;
(o) safeguard information provided by clients. Except where required by law or court order, a CBHPSS shall obtain the client's informed written consent prior to releasing confidential information;
(p) disclose the estimated fees and/or the method of fee calculation to the client or prospective client, and obtain written acknowledgement of the disclosure;
(q) respect and protect the confidentiality, rights, and dignity of those they serve;
(r) advocate for those they serve unless it would threaten the safety, security, or recovery of others;
(s) take proper and adequate measures to prevent, report, and correct unethical conduct;
(t) follow all state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR part 2;

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(u) as mandatory reporters, report elder abuse and child abuse to appropriate authorities and supervisors;
(v) disclose any pre-existing relationships, sexual or otherwise, to immediate supervisor prior to providing services to that individual; and
(w) report risk of imminent harm to self or others to the proper authorities and to their supervisor. When reporting, the minimum amount of information necessary will be given to maintain confidentiality.

(3) A CBHPSS shall not:
(a) commit fraud or misrepresent services performed;
(b) engage or offer advice on the matters of diagnosis, treatment, or medications;
(c) divide a fee or accept or give anything of value for receiving or making a referral;
(d) violate a position of trust by knowingly committing any act detrimental to a client;
(e) engage in or promote behaviors or activities that would jeopardize the CBHPSS's recovery or the recovery of those they serve;
(f) participate in bartering, unless bartering is considered to be essential for the provision of services negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. A CBHPSS who accepts goods or services from a client as payment for professional services assumes the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship;
(g) exploit in any manner the professional relationships with clients or former clients, supervisees, supervisors, students, employees, or research participants;
(h) engage in or solicit sexual contact with a client or commit an act of sexual misconduct or a sexual offense if such act, offense, or solicitation is substantially related to the qualifications, functions, or duties of the CBHPSS;
(i) enter into sexual or personal relationships with a client or a client's immediate family member;
(j) condone or engage in sexual harassment. Sexual harassment is defined
as deliberate or refuted comments, gestures, or physical contact of a sexual nature that are unwelcome by the recipient;
(k) discriminate in the provision of services on the basis of race, creed, religion, color, sex, physical or mental disability, marital status, age, or national origin;
(l) abuse, harass, demean, or discriminate against others based on race, culture, religion, age, gender, gender identity, disability, nationality, sexual orientation, or economic condition;
(m) provide professional services while under the influence of alcohol or other mind-altering or mood-altering drugs which impair delivery of services; or
(n) engage in any advertising which is in any way fraudulent, false, deceptive, or misleading.

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FINGERPRINTING & BACKGROUND CHECK INSTRUCTIONS

- The fingerprint and background check process may be a lengthy with the Department of Justice, Criminal Records, DOJ. For this reason, you are encouraged to complete your paperwork for the process ASAP.

- Read and attest to reading the Noncriminal Justice Applicant's Rights form (the form is included in this packet). Sign and return the form to the Board office.

- Fingerprint cards are available from most local law enforcement agencies and the Montana DOJ. A sample card specific to peer support specialists is attached. Complete the information requested at the top of the fingerprint card prior to having your prints taken and include the following information:

EMPLOYER & ADDRESS:	MT. Dept. of Labor & Industry MT. Board of Behavioral Health Peer Support Specialist Certification 301 South Park Ave, 4th Floor PO Box 200513 Helena, MT 59620-0513
REASON FINGERPRINTED:	§ 37-38-202 MCA Certified Behavioral Health Peer Support Specialist Applicant
ORI NUMBER:	MT920095Z

- To expedite the process, applicants are encouraged to have prints taken at a facility that provides digital prints.

- Most local law enforcement agencies will take your fingerprints for a nominal fee. After paying this fee and having your fingerprints taken, **send the completed fingerprint card along with a check or money order for $27.25 made payable to the Montana Department of Justice and mail it to Montana Criminal Records, 2225 11th Avenue, PO Box 201403, Helena, MT 5960-1403.** Please check with your local post office and add accurate postage prior to mailing.

- If DOJ rejects your first prints as "unreadable", the Board office will notify you and you will need to re-submit your fingerprints. You are not required to repay the processing fee to the Montana Department of Justice under these circumstances.

- Criminal History Record Information (CHRI) from the fingerprints is only released to the Board of Behavioral Health. Your process will not be considered complete until the CHRI is received from the DOJ.

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Non-Criminal Applicant's Rights Form / Consent to Fingerprint

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification by the Board of BEHAVIORAL HEALTH that your fingerprints will be used to check the criminal history records of the FBI.
- You must be provided, and acknowledge receipt of, an adequate Privacy Act Statement when you submit your fingerprints and associated personal information. This Privacy Act Statement should explain the authority for collecting your information and how your information will be used, retained, and shared.
- If you have a criminal history record, the officials deciding of your suitability for employment, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the criminal history record.

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge.

If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at http://www.fbi.gov/about-us/cjis/background-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI at the same address as provided above. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency.

If a change, correction, or update needs to be made to a Montana criminal history record, or if you need additional information or assistance, please contact Montana Criminal Records and Identification Services at dojitsdpublicrecords@mt.gov or 406-444-3625.

Your signature below acknowledges this agency has informed you of your privacy rights for fingerprint-based background check requests used by the agency.

Signed:

Signature ______________________________ Date

Printed Name ______________________________ Date

8 Written notification includes electronic notification, but excludes oral notification.9 See 28 CFR 50.12(b). 10 See 5 U.S.C. 552(a)(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d). In accordance with federal law regarding notices and disclosures, MT Dept. of Justice requires the entity to which you are applying to work or volunteer to use this form. Form number APR&CF 20170213

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PRIVACY ACT STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized nongovernmental agencies responsible for employment, contracting licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Additional Information: The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any systems(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

In accordance with federal law regarding notices and disclosures, MT Dept. of Justice requires the entity to which you are applying to work or volunteer to use this form. Form number APR&CF 20170213

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APPLICANT
FD-258 (REV 3-1-10) 1110-0046

LEAVE BLANK — For FBI Use Only

TYPE OR PRINT ALL INFORMATION IN BLACK

LAST NAME NAM	FIRST NAME	MIDDLE NAME
Doe	John	Joseph

FBI LEAVE BLANK — For FBI Use Only

SIGNATURE OF PERSON FINGERPRINTED: Applicant's Signature

ALIASES AKA: Smith, Robert (Used By Applicant) Include maiden and nicknames

ORI: MT920095Z

RESIDENCE OF PERSON FINGERPRINTED: Applicant's Present Address

DATE OF BIRTH DOB (Month Day Year): 01 01 1950

CITIZENSHIP CTZ: US or Foreign Country

SEX	RACE	HGT	WGT	EYES	HAIR	PLACE OF BIRTH POB
M	W	508	165	Bro	Bro	State Or Country

DATE: Date Prints Taken

SIGNATURE OF OFFICIAL TAKING FINGERPRINTS: Enter Name of Official Taking Prints

YOUR NO. OCA

EMPLOYER AND ADDRESS:
MT Dept of Labor and Industry
301 S Park 4th Fl
PO Box 200513
Helena MT 59620

FBI NO. FBI: For FBI Use Only

ARMED FORCES NO. MNU

LEAVE BLANK — CLASS — REF.

REASON FINGERPRINTED:
MtCA 37-38-202
Behavioral Health Support applicant

SOCIAL SECURITY NO. SOC: Enter Social Security # If available

MISCELLANEOUS NO. MNU

Make A Notation In The Appropriate Finger Blocks If Applicant Is Missing One Or More Fingers For Any Reason. If Not Missing, All Ten Impressions Must Be Provided With Scars And Deformities Notated.

1. R. THUMB | 2. R. INDEX | 3. R. MIDDLE | 4. R. RING | 5. R. LITTLE

Use Care And Save Time By Assuring All Impressions Are Taken In Correct Sequence, Are Legible, Fully Rolled And Classifiable. Make Sure That All Requested Data Has Been Provided. Unclear Prints Will Be Rejected. Fingerprint Cards Which Are Not Prepared Correctly Will Be Returned

6. L. THUMB | 7. L. INDEX | 8. L. MIDDLE | 9. L. RING | 10. L. LITTLE

Sample

LEFT FOUR FINGERS TAKEN SIMULTANEOUSLY | L. THUMB | R. THUMB | RIGHT FOUR FINGERS TAKEN SIMULTANEOUSLY

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DECLARATION

I authorize the release of information concerning my education, training record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Behavioral Health. I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant ____ Date ____________

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LEGAL, HEALTH, and ADDICTION DEPENDENCY HISTORY GUIDELINE

It is the Board's duty to protect the public and ensure, to the best of their ability, public safety. Responses to application questions related to a legal, health, or addiction issues may have an impact on practice and the safety and welfare of the public. When such responses occur a designation of non-routine application is used and steps occurs in processing the application. To effectively and efficiently processing your application we ask the following:

If you answer "yes" to any question from #12 - # 29 please respond to items 1-2 below. All items may not apply to your application but for the ones that do, please provide a thorough response. Providing the requested material with your initial application ensures prompt processing of the application. If any of the items do not apply to your situation, please indicate so in your written response. Please be as thorough as possible in responding and if you have any questions, please don't hesitate to call or write the Board office.

"From the source" means documents are sent to the Board office directly from the court, probation or parole, or service delivery agencies such as a mental health or addiction treatment facilitates of practicing professionals. All requests for documents in the categories below must be received "from the source."

Legal History, current and past issues, questions 12-18

1. Documentation of all criminal charges via court records i.e., charging documents, plea agreements, judgements, sentencing, and probation/parole reports. Supporting documents must be provided from the source.

2. A *detailed account in your own words*, of the circumstances surrounding all legal charges against you.

Physical or Mental Health Disorder in the past 5 years, question # 21

Within the past 5 years, have you any physical or mental health condition(s), other than as answered in question 19, which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving risk to the public? If yes, attach a detailed explanation.

1. Provide documentation of all medical and mental health services including evaluations, diagnosis, treatment recommendations, discharge summary and prognosis, and/or monitoring. Supporting documents must be provided from the source.
2. A *detailed account in your own words*, of your participation in all health, mental health, and addiction treatment episodes.

Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program?

1. Provide documentation of all addictive disorders treatment services including evaluations, diagnosis, treatment recommendations, discharge summary and prognosis, and/or monitoring. Supporting documents must be provided from the source.

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Licensing Phone Number: 406-444-5773
E-Mail: dlibsdbbh@mt.gov **Website:** www.bbh.mt.gov

2. A *detailed account in your own words*, of your participation in all mental health and addiction treatment episodes. Again, the what, when, where, how and the circumstances of your life at the time of the physical or mental health issues at the time.

MONTANA BOARD OF BEHAVIORAL HEALTH
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BEHAVIORAL HEALTH DISORDER RECOVERY

To qualify as a Certified Behavioral Health Peer Support Specialist, you are required to have a "behavioral health disorder" and be engaged in "behavioral health disorder recovery" or "recovery from a behavioral health disorder".

"Behavioral health disorder recovery" or "recovery from a behavioral health disorder" means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Eligibility for certification is contingent on the applicant's behavioral health disorder recovery that does not include any period of incarceration, or hospitalization or any inpatient admission related to a behavioral health disorder that exceeds 72 hours, within the two years immediately preceding application for certification.

If you have an ethical or legal history, the Board will ask for a personal account of your recovery program to gauge your risk to the public and or your rehabilitation. Please know that this is the Board's duty and it occurs with ALL credentials under the Board of Behavioral Health as well as many other professions under the Department of Labor and Industry. If ethical or legal issues are not partnered with your behavioral health diagnosis you may simply attest to the disorder without providing your personal account.

In your own words describing your current recovery program. The account should include physical, emotional, mental, social, financial, and spiritual aspects of *your* recovery program. Examples may include attendance at 12-step or alternative support groups, sponsorship; physical components may include exercise, yoga, or weightlifting; spiritual aspects perhaps a religious affiliation or cultural practice—i.e., sweat lodge or smudging; emotional or mental examples may include therapy, a life coach, journaling, sponsorship, gender specific groups. It is recognized that recovery programs vary and are as individual as those that establish them. We are interested in your process and what elements sustain you and your wellbeing.