Peer Professional Training (PPT)

**& Placement Program Application**

*Project Return Peer Support Network*

* **Applicant Requirements:**
	+ Applicants ***must have*** personal lived experience with a mental illness ***and*** have experience as a consumer of services in the mental health system. Applicants must also identify themselves as a person who has used, or uses, mental health services in their own recovery process. **OR** applicants must be an immediate family member of a person with a mental illness who has had experience as a consumer of services.
	+ Applicants ***must plan*** to attend all sessions, which include classroom instruction via Zoom, and volunteer/internship field placement. Notification of any need to miss a class or leave early must be done ***verbally and in writing at least 24-hours in advance.***
	+ Applicants ***must*** secure their own transportation to internship sites in addition to the classroom in Huntington Park. **(Currently all training and internships are online via Zoom.).**
	+ Applicants ***must*** be able to communicate effectively using written and verbal skills.
	+ Applicants ***must*** complete the application ***using a computer***, independently and in their own words.
	+ Applicants ***must*** have basic computer skills.
* **Instructions:**
	+ All requested information must be provided and every question on this application must be completed. (*Note: This DOES NOT include the “Voluntary Disclosure of Self-Identification” form on Page 8).* Incomplete applications are defined as containing ***any blank information box or partially-answered essay question.*** If you need additional sheets, please put your name on each sheet and send them ***with*** your application.
	+ **Applications must be completed using a computer.** You may type directly into the application, print it out, and mail the completed application to PRPSN, 2677 ½ Zoe Ave., Huntington Park, CA 90255, Attn: Jason Garcia or fax your application to: 323-312-0642. Completed applications can also be emailed to: jgarcia@prpsn.org and/or hpiceno@prpsn.org.
	+ Each candidate ***must attend an interview*** before acceptance into the program. Dates/times for the interviews will be scheduled by the PRPSN Training Team.
	+ Please write your name on the bottom of each page of the application and send ***all pages together as a complete packet***.

**Name:**

**Project Return Peer Support Network**

**PPTP Applicant’s Contact Information**

|  |
| --- |
| **Name:**  |
| **Address,**  |
| **Email Address:** |
| **Home Phone:**  | **Cell Phone:**  |

***\*\*\*\*Any phone number you provide PRPSN must be a consistently working phone number\*\*\****

**Alternative Contact Information:** This is someone who could be reached in case of emergency or as a way to contact you if the information you provided above changes:

|  |
| --- |
| **Name:**  |
| **Address, City, Zip:**  |
| **Email Address:**  |
| **Home Phone:**  | **Cell Phone:**  |

**How did you hear about the Peer Professional Training & Placement program?**

|  |
| --- |
|  |

**Have you applied to Project Return Peer Support Network training(s) in the past? (If yes, please state years and outcomes)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:**

**PPTP Applicant Written Essay**

**Please answer all of the questions below in your own words. Please type your answers in the available space or on separate sheets (please ensure your application is legible). ALL ADDITIONAL SHEETS MUST BE SUBMITTED WITH THE APPLICATION & INCLUDE APPLICANT’S NAME.**

1. **Please describe how your personal lived experience of a mental health issue has made you the person you are today.**

|  |
| --- |
|  |

1. **Please describe your understanding/definition of a “peer professional.” What you think are the necessary skills peer professionals should possess? What do you expect to learn by the end of the training?**

|  |
| --- |
|  |

**Name:**

1. **What, if any, professional experience have you already had outside the mental health field? What is your long-term career goal, and how will participation in this training help you realize that goal?**

|  |
| --- |
|  |

1. **“Recovery” is a term often used in mental health care. Please define your *personal* definition of recovery, making sure to answer: What does recovery look like? Sound like? Feel like?**

|  |
| --- |
|  |

**Name:**

1. **Who is your personal inspiration? (This can include professionals, family, peers and/or friends). Describe, providing a specific example, *how* this person has influenced your life.**

|  |
| --- |
|  |

1. **What are the strengths that will assist you in fulfilling the obligations of this training course? What areas (time, distance, length of course, etc.) present challenges for you, and how do you plan to overcome those challenges if chosen to participate?**

|  |
| --- |
|  |

**Name:**

**PPTP Applicant Education & Career Accomplishments**

*Please provide as much information as possible related to your past and current education/training/ employment/volunteer experience. Lack of previous education/training or paid employment will not disqualify you. Please provide additional sheets if necessary*

**\*\*\*Education/Training – List all education/training, beginning with the most recent.\*\*\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Training or Agency** | **Degree/Certificate** | **Field of Study** | **Date(s)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**\*\* Paid/Unpaid Employment/Volunteer Experience – List all prior positions, starting with the most recent. \*\*\***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Agency & Supervisor Name** | **Your Title** | **City and State** | **Dates** | **Volunteer or Paid** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Name:**

**PPTP Participant Agreement Form**

Read each of the following statements thoroughly! **Initial each box, next to the statement you agree with.**

**Agreements for Participation.** Please read each statement thoroughly!

**Initial each box next to the statement you agree with.**

 I completed this application on my own.

\_\_\_ I used a computer to complete the application.

 I answered all questions in my own words.

 I intend to enter the mental health field either as a volunteer or paid employee upon completion of this course.

 I intend to participate to my maximum ability during the five-week training, including the classroom and internship obligations. Repeated absences of 3 will result in elimination from the course.

  ***I understand that Project Return Peer Support Network is not a job placement program, and that PRPSN is under no obligation to find me a job or ensure my employment.***

 I understand that the content of the training is to provide me with core skills necessary for Peer Professional and/or entry level positions in the mental health field.

 I agree to complete ***all required homework, classroom assignments and internship responsibilities***.

 I understand that in order to receive a certificate of completion, I must graduate from the class with everything completed including the internship. If for some reason, the internship is not completed by the end of the session, I understand that I will only receive a certificate of participation until all hours of the internship are completed.

Type your name here:

Your signature:

Date:

**Name:**

**VOLUNTARY DISCLOSURE OF SELF-IDENTIFICATION**

This demographic survey is being administered by the Office of Statewide Health Planning and Development (OSHPD) who funds your participation in this program. In efforts to collect data that enables the evaluation of the program’s effectiveness towards serving diverse populations, this survey aims to collect data on the wide range of demographics of our program participants. While this survey is optional, OSHPD kindly requests your completion of this anonymous survey.

Please identify your county of residence: Name of County

**Please identify your Ethnicity/Race:**

\_\_\_ Black/African American/African \_\_\_ Latinx/Hispanic

\_\_\_ American Indian/Native American/Alaskan Native \_\_\_Central American

\_\_\_ Asian \_\_\_ Cuban

 \_\_\_Cambodian \_\_\_ Mexican

 \_\_\_Chinese \_\_\_ Puerto Rican

 \_\_\_Filipino \_\_\_ South American

 \_\_\_Indian \_\_\_ Other Hispanic

 \_\_\_Japanese \_\_\_Middle Eastern

 \_\_\_Laotian/Hmong \_\_\_Pacific Islander

 \_\_\_Korean \_\_\_Fijian

 \_\_\_Pakistani \_\_\_Guamanian

 \_\_\_Thai \_\_\_Hawaiian

 \_\_\_Vietnamese \_\_\_Samoan

 \_\_\_Other \_\_\_Tongan

\_\_\_Caucasian/White/European \_\_\_Other Pacific Islander

\_\_\_Decline to State

**Please select any languages you speak in addition to English:**

\_\_\_American Sign Language \_\_\_Hmong \_\_\_Samoan

\_\_\_Arabic \_\_\_Italian \_\_\_Spanish

\_\_\_Armenian \_\_\_Japanese \_\_\_Tagalog

\_\_\_Cambodian \_\_\_Khmer \_\_\_Thai

\_\_\_Cantonese \_\_\_Kiswahili \_\_\_Turkish

\_\_\_Chinese \_\_\_Korean \_\_\_Urhobo

\_\_\_Farsi \_\_\_Laotian \_\_\_Vietnamese

\_\_\_French \_\_\_Mandarin \_\_\_Other

\_\_\_German \_\_\_Polish

\_\_\_Haitian Creole \_\_\_Portuguese

\_\_\_Hebrew \_\_\_Punjabi

\_\_\_Hindi \_\_\_Russian

**Not everybody uses the same labels, however, which BEST describes your current gender:**

\_\_\_Androgynous \_\_\_Male/Transman/FTM Transgender

\_\_\_Female \_\_\_Questioning my Gender

\_\_\_Female/Transwoman/MTF Transgender \_\_\_Decline to State

\_\_\_Male

**Not everybody uses the same labels to describe their sexual orientation, however, which BEST describes your sexual orientation:**

\_\_\_Bisexual/Pansexual

\_\_\_Gay

\_\_\_Heterosexual/Straight

\_\_\_Lesbian

\_\_\_I’m questioning whether I’m straight or not straight

\_\_\_Queer

\_\_\_Decline to State

**Please identify if you are a consumer and/or a family member:**

\_\_\_Consumer \_\_\_Both

\_\_\_Family Member \_\_\_None

\_\_\_Decline to State

**Do you identify as having a disability\*?**

\_\_\_Yes \_\_\_No

\_\_\_Decline to State \_\_\_None

\*A disability is defined as an individual who: 1) has a physical or mental impairment or medical condition that limits one or more life activities, such as walking, speaking, breathing, performing manual tasks, seeing, hearing, learning, caring for oneself or working; 2) has a record or history of such impairment or medical condition; or 3) is regarded as having such an impairment or medical condition.

**Please select your age group:**

\_\_\_Under 18 \_\_\_40-64

\_\_\_18 – 24 \_\_\_65 years and over

\_\_\_25 – 39 \_\_\_Decline to State

**Are you a Military Veteran?**

\_\_\_Yes \_\_\_No

**Have you ever been arrested?**

\_\_\_Yes \_\_\_No \_\_\_Decline to State

**Have you ever been convicted of a crime?**

\_\_\_Yes \_\_\_No \_\_\_Decline to State

**THANK YOU!**