

Bureau for Medical Services:

West Virginia Peer
Recovery Support
Specialist Certification
Application



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Cabinet Secretary

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Cynthia E. Beane
Commissioner

PEER RECOVERY SUPPORT SPECIALIST CERTIFICATION APPLICATION FORM

PLEASE CLEARLY PRINT OR TYPE RESPONSES

A fillable form is available for download on our website:

[https://dhhr.wv.gov/bms/Programs/WaiverPrograms/Pages/Substance-Use-Disorder-\(SUD\)-Waiver-.aspx](https://dhhr.wv.gov/bms/Programs/WaiverPrograms/Pages/Substance-Use-Disorder-(SUD)-Waiver-.aspx)

APPLICANT INFORMATION

Name: _____ Date of Birth: _____
(LAST NAME) (FIRST NAME) (MI) (MM/DD/YYYY)

Maiden and/or Former Name: _____ Title: Mr. Mrs. Ms. Other: _____

Telephone: _____ Last 4 Digits of SS: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Today's Date: _____

E-mail*: _____

** Notification of application receipt will be issued via email. Individuals without an email account who desire confirmation must request a mailed confirmation on the line above.*

APPLICATION TYPE: INITIAL RE-CERTIFICATION

- 1) Have you experienced any mental health or substance use challenges?
 YES NO If NO, please explain: _____
- 2) Are you currently involved with a personal support and/or recovery system?
 YES NO If NO, please explain: _____

Please include three (3) Letters of Reference, one (1) page or less in length, from individuals familiar with your Service Experience. NOTE: References will return their letters to the applicant in a sealed envelope with the Reference's signature across the seal. Letters must be submitted with the application packet.

Reference Name: _____

Reference Name: _____

Reference Name: _____

EDUCATION INFORMATION

- 1) Do you have a High School Diploma or GED? YES NO
- 2) Name of last school attended: _____ City: _____ State: _____
- 3) Indicate the last year of school completed: 6 7 8 9 10 11 12 13 14 15 16+
- 4) Indicate the highest degree earned: H/S GED Associate Bachelors Masters Doctorate Other

PROFESSIONAL INFORMATION

The following statement applies to Questions 1-8 of this section: ***In West Virginia or in any other state, the District of Columbia, a United States territory, or a foreign jurisdiction,***

- 1) Have you ever been licensed, certified, or registered as a Peer Recovery Support Specialist, or any other behavioral health professional? NO YES If yes, please explain:
Credential Type: _____ Issue Date: _____
State/Region: _____ Expiration Date: _____
- 2) Have you ever:
- Had your license, certification, or registration to practice suspended, revoked, surrendered or subjected to any kind of disciplinary action? NO YES
 - Had a complaint filed against your behavioral health and/or community practice? ***You do not need to report any complaints dismissed without merit.*** NO YES
 - Been convicted of a felony and/or crime that harmed another person? NO YES

Attach a page fully explaining the circumstances/details of any questions marked 'YES'

SERVICE AGENCY INFORMATION

Agency Name: _____

Position: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Agency Phone Number: _____ Still Working Here: YES NO

Average Hours per Week: _____ Supervisor: _____

Date Started: _____ How Long There: _____

Position Type: Full-time Employment Part-time Employment

Area of Focus: Substance Use Co-Occurring

If you have worked at additional agencies, please attach additional page(s) with details using the format above.

Peer Recovery Support Specialist (PRSS) Attestation of Recovery

I, the undersigned individual, affirm that I have read and agree to adhere to the National Certified Peer Recovery Support Specialist Code of Ethical Standards and understand that violation of these Ethical Standards may result in loss of certification, and possibly other penalties.

Applicant Signature/Date

Please Print or Type Your Name

Statement of Personal Recovery

I, the undersigned individual, affirm that I have successfully pursued my own personal health recovery experience involving the use of alcohol and/or other drugs. I affirm that I have not used any alcohol, opiate, narcotic, barbiturate, stimulant, or other drug affecting my central nervous system, or other drug causing physical or psychological dependence, to which I was addicted or upon which I was previously dependent, within the past two years. I further affirm that I have not used controlled substances which were obtained illegally, or mis-used any controlled substances which were obtained with a valid prescription order from a licensed health care provider, within the past year. I affirm that in the event I experience a relapse in my recovery or experience other psychological or physical health conditions which may interfere with and impair my professional functioning, I will seek appropriate therapeutic care, and I will request an inactive status as a Peer Recovery Support Specialist for medical reasons for as long as is necessary.

(Optional) My present period of continued recovery from alcohol or other psychoactive drugs is _____ years and/or _____ months.

Applicant Signature/Date

Please Print or Type Your Name