ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Peer Support

I. Service Capacity

A. 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.

B. Describe your service capacity throughout the State. Specify any areas that you do not provide Peer Support:

C. Describe your capacity to provide translation for consumers when needed.

Language	# Administrative Staff (if applicable)	# Certified Older Adult Peer Specialists (COAPS)

If you have no translation capacity, describe your procedure for serving consumers who have limited English-speaking ability.

D. 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.

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

II. General Policies and Procedures

A. 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

A. 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

A. For Agencies employing COAPS, describe your orientation.

V. Supervision

A. 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: _____

SERVICE SPECIFIC ON-SITE REVIEW

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					

SERVICE SPECIFIC ON-SITE REVIEW

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