State of Indiana Family and Social Services Administration (FSSA)/ Division of Mental Health and Addiction (DMHA)

Certified Parent Support Provider Application

Name *(please print)* _____

Address _____

City_____ **State**_____ **ZIP**_____

Email _____ **Phone** _____ **Cell** _____

Child[ren]'s D.O.B.: _____

All applicants will be expected to submit to the following screenings after the training and the passing of the Parent Support Provider exam as part of the certification requirements :

- **Finger-print based national and state criminal history background screen**
- **Local law enforcement screen**
- **State and local Department of Child Services abuse registry screen**
- **5- Panel Drug Screen**

All applicants must complete the following application and meet all of the eligibility requirements in order to participate in the Certified Parent Support Provider training program.

1) Do you meet the requirement of being 21 years of age or older? Please attach proof of age.

Yes ☐ **No** ☐

2) Do you meet the requirement of having a valid Indiana driver's license and reliable transportation? Please bring proof of license.

Yes ☐ **No** ☐

3) Do you meet the requirement of having earned a high school diploma or GED?

Yes ☐ **No** ☐

4) Do you meet the requirement of having basic computer skills including Microsoft Office?

Yes ☐ **No** ☐

5) Are you willing and able to attend 40-hour 5-day training?

Yes ☐ **No** ☐

6) Are you currently or have you been the parent or guardian of a child or youth between the ages 6 -18 diagnosed with a serious emotional disturbance (SED) and/or co-occurring disorder diagnosed by a physician or psychologist?

Yes ☐ **No** ☐

Name of physician or psychologist _____

7) Have you had at least 2 years experience within the last eight years being the parent/guardian of a child/youth (between the ages 6-18) with a SED and/or co-occuring disorder?

Yes ☐ **No** ☐

Date (can be approximate) and name of diagnosis_____

8) Please list the systems (school, juvenile justice, Wraparound, mental health system, etc.) you navigated while caring for your child.

_____ _____

_____ _____

_____ _____

9) Please list your strengths (patient, hardworking etc. if you cannot think of any, what would your family/friends say were your strengths)

_____ _____

_____ _____

_____ _____

10) Briefly describe (5-10 sentences) your experience as a parent/guardian of a child experiencing SED and/or co-occurring disorder in the early days of the diagnosis (only share what you are comfortable sharing).

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11) Briefly describe (5-10 sentences) your experience as a parent/guardian of a child experiencing SED and/or co-occurring disorder today (only share what you are comfortable with sharing).

12) Briefly describe (5-10 sentences) why you would like to become an Indiana Certified Parent Support Provider?

Please include the name and contact information for three references:

1. _____

_____

2. _____

_____

3. _____

_____

You may use this space for any additional information you would like to include.

_____

_____

_____

_____

_____

_____

My signature affirms that all of the information contained in this application is true and correct to the best of my knowledge and has been completed by no other person. I understand that knowingly providing false information will be grounds to deny or terminate my certification.

Applicant's signature _____ **Date**_____

If you have any questions or concerns, please contact Erin Tock at etock@namiindiana.org or call 317-925-9399 or 800-677-6442.

Return application to: NAMI Indiana
2601 Cold Spring Rd
Indianapolis, IN 46222

Fax to: NAMI IN, Attn. Erin Tock 317-925-9398

Email to:Erin Tock, etock@namiindiana.org