



STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
OFFICE OF STATEWIDE SYSTEMS OF CARE
Andrew Jackson Building, 5th Floor
500 Deaderick Street
NASHVILLE, TENNESSEE 37243

CERTIFIED FAMILY SUPPORT SPECIALIST Application

Name (*please print*) _____

Address _____

City _____ State _____ ZIP _____

Phone (____) _____ - _____ Work (____) _____ - _____

Email _____

- 1) The OSSOC requires a minimum of a high school diploma or GED. Do you have a high school diploma or GED? If yes, please attach a copy.

Yes No

- 2) Are you employed by an agency that is a TDMHSAS-licensed or otherwise approved agency and under the direct supervision of a mental health professional in accordance with acceptable guidelines and standards of practice as defined by TDMHSAS?

Yes No

If Yes, please have your immediate supervisor complete and submit the attached Employment Summary Form to the OSSOC with attention to Melissa McGee at Melissa.McGee@tn.gov or by fax: 615-253-6822.

- 3) Are you/have you been the caregiver of a child or youth diagnosed with a mental, emotional, behavioral or co-occurring disorder by a physician or psychologist?

Yes No

- 4) Have you self-disclosed that you are or have been a caregiver of a child or youth who is diagnosed with a mental, emotional, behavioral or co-occurring disorder and who is receiving or has received mental health or co-occurring disorder services?

Yes No

5) In the last five (5) years, have you actively participated in a minimum of twelve (12) consecutive months in the service planning , system navigation, and building resiliency for a child or youth with a mental, emotional, behavioral, or mental health disorder? (must show experience in leadership, advocacy, and support)

Yes No

6) Have you demonstrated successful completion of the required evidence-based and/or best practice Family Support Specialist Training Programs recognized by TDMHSAS? If yes, please attach copies of the certificates of completion.

Yes No

7) Have you worked with other caregivers of children or youth diagnosed with emotional, behavioral or co-occurring disorders for at least six (6) months (paid or volunteer) as a family support specialist, support group facilitator, caregiver educator, or other relevant experience?

Yes No

8) Indicate below the paid and/or volunteer experiences you have had in working with other caregivers of children who are recipients of mental health or co-occurring disorder services:

a) Family Support Specialist Years ___ Months ___ **(circle one)** Paid / Volunteer
Current Position? Yes ___ No ___

Agency _____

Phone Number (____) _____ - _____

Position Held _____

Briefly Describe Your Work Responsibilities: _____

Supervisor's Name _____

Phone Number (____) _____ - _____

b) Support Group Facilitator Years ___ Months ___ **(circle one)** Paid / Volunteer
Current Position? Yes ___ No ___

Agency _____

Phone Number (____) _____ - _____

Position Held _____

Briefly Describe Your Work Responsibilities: _____

Supervisor's Name _____

Phone Number (____) _____ - _____

c) Caregiver Educator Years ____ Months ____ **(circle one)** Paid / Volunteer

Current Position? Yes ____ No ____

Agency _____

Phone Number (____) _____ - _____

Position Held _____

Briefly Describe Your Work Responsibilities: _____

Supervisor's Name _____

Phone Number (____) _____ - _____

d) Other Relevant Experience Years ____ Months ____ **(circle one)** Paid / Volunteer

Current Position? Yes ____ No ____

Agency _____

Phone Number (____) _____ - _____

Position Held _____

Briefly Describe Your Work Responsibilities: _____

Supervisor's Name _____

Phone Number (____) _____ - _____

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 _____