

KY Department for Behavioral Health, Developmental and Intellectual Disabilities
Family Peer Support Specialist 30 Hour Training
Single Curriculum Submission Summary

The KY Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) recommends use of the Family Peer Support Specialist rubric and related documents to ensure providers' submission of all necessary materials. This will allow the DBHDID staff to review the curricula in their entirety and make an approval decision or request supplementary materials in an efficient manner, within the period specified. Please complete the below information and submit all materials following the instructions below.

Today's Date:

Provider Information

Name of Provider:

Mailing Address Line 1:

Mailing Address Line 2:

City, State, Zip Code:

Contact Person

Name of Person Completing this Form:

Phone Number:

Email Address:

Author of Curriculum* (if different from the Contact Person above)

Author Name:

Phone Number:

Email Address:

*Are you submitting, with permission, a curriculum with no revisions owned by another entity that has previously submitted to DBHDID? Yes ☐ No ☐

Trainer Information

For this training to achieve the intended specific knowledge and skills needed by the trainee there should be at a minimum one (1) family member who has lived experience and has received certification as a Family Peer Support Specialist who will assist and participate in the provision of the training. List the trainer(s) below:

1. Name:
Email Address:

2. Name:
Email Address:

3. Name:
Email Address:

4. Name:
Email Address:

At least one **Agency staff member** who will assist and participate in the provision of the training:

1. Name:
Email Address:

2. Name:
Email Address:

3. Name:
Email Address:

Submission of Documents and Materials

The below is a checklist of items to include on the USB flash drive:

- ☐ Curriculum (saved as a Word, Power Point and/or PDF files)
- ☐ Curriculum rubric (saved as a Word or PDF file) (recommended)
- ☐ Evaluation form to be used at the training
- ☐ Trainee test to be used at the training

On the flash drive, clearly label the flash drive with the provider's name. ***Submit this document and the USB flash drive to the below address.***

Submit this information to:
Department for Behavioral Health, Developmental and Intellectual Disabilities
Division of Program Integrity
Program Support Branch
275 East Main Street, 4E-C
Frankfort, KY 40621