Missouri
Credentialing Board

(573) 616-2300 www.missouricb.com email: help@missouricb.com 428 E. Capitol, 2nd Floor Jefferson City, MO 65101

MRSS-P MCB Exceptions Process

Typically, no individual currently under any type of court or Department of Corrections (DOC) supervision may apply for a MCB credential. However, a MCB exceptions process has been created to allow someone still under either type of supervision to obtain the Missouri Recovery Support Specialist-Peer (MRSS-P).

If you are currently under any type of court or DOC supervision, you should request and be approved for a MCB exception before submitting a MRSS-P application. You may not apply for a MCB exception until 2 years from either your prison release date if you were sentenced to prison or if you were not sentenced to prison, 2 years from your sentencing date. Please note that if you are under court or DOC supervision for an offense listed on the www.missouricb.com Disqualifying Crimes Link, you must obtain a Department of Mental Health exception first. Please contact DMH at 573-751-8202. If you are under court or DOC supervision your Probation or Parole Officer must complete the Probation and Parole Summary Report on pages 4 and 5 of this application.

If you are **not** under any type of court or DOC supervision, you can skip the MCB exception process and proceed to page 6 of this application.

Following is the process to be granted a MCB exception:

1. Submit the following items to the MCB office at MCB, 428 E. Capitol, 2nd Floor, Jefferson City, MO 65101.
   A. A $25.00 processing fee. This fee is non refundable whether or not the exception is approved.
   B. A completed Family Care Safety Registry form (page 17 of this application)
   C. A completed Exceptions Offense Form (pages 2 and 3 of this application)
   D. If applicable, provide the dates and names of any Educational or Training Institutions you have attended since the crime(s) you listed on the Exceptions Offense Form.
   E. If applicable, provide the dates and names of any Substance Use Disorder Treatment Programs you have attended since the crime(s) you listed on the Exceptions Offense Form.
   F. If applicable, provide any important life changes since the crime(s) you listed on the Exceptions Offense Form. Include life changes such as marriage, divorce, military service, etc…
   G. If applicable, provide a short work history since the crime(s) you listed on the Exceptions Offense Form.
   H. Three (3) Recommendation letters to include the following:
      1. A Professional recommendation from an employee who is currently involved in directly supervising your court or DOC supervision.
      2. A Professional recommendation. This can be someone who has known you in a work related or educational capacity.
      3. A general recommendation letter from someone of your choice.
      4. All 3 recommendation letters should include the person's name, a contact phone number, address, date the letter was written, the capacity in which the person knows you, how long the person has known you and a lengthy explanation of why he/she believes the MCB should grant you a credentialing exception. All letters must be written within 90 days of applying.

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MCB EXCEPTIONS OFFENSE FORM

NAME: _____

Arrest(s) and date(s):_____
_____
_____

Conviction(s) and date(s):_____
_____
_____

State where arrest/conviction occurred: _____

For an arrest/conviction in any state other than Missouri, request your criminal history report from that state to include with this Exceptions Offense Form.

Sentence(s) received for conviction(s), including any probation or parole: _____
_____
_____

Dates sentence(s) served and date(s) sentence will be completed: _____
_____
_____

Type of court or DOC supervision you are presently under: (parole, supervised probation, etc.)
_____
_____

Provide details related to your arrest(s)/conviction(s):
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If your offense was related to alcohol/drug addiction, please provide information and/or documentation regarding any purported recovery time.

_____
_____
_____
_____
_____
_____

Use this space to make any other comment or statement regarding your arrest(s) or conviction(s) and your life since:

_____
_____
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_____

APPLICANT'S SIGNATURE:

Your signature assures that all of the information that you provided in this form is complete and true and that you accept the Board's responsibility and authority to approve or not approve your exceptions request.

_____

Applicant's Signature Date

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MCB Application
Probation and Parole Summary Report

Date:

Client Name:

Client Number:

Date of Birth:

Offense:

Date Supervision Began:

Potential Discharge Date:

1. Is the client currently attending treatment? If so, please indicate type of treatment. (i.e. outpatient, residential, inpatient)

2. Has the client previously attended treatment in the community? If so, please indicate the type of treatment, date, location and if there was a successful or unsuccessful outcome.

3. Has the client attended Institutional Treatment at a DOC facility? If yes, please indicate the date, DOC facility and if there was a successful or unsuccessful outcome.

4. Has the client been violation free in the last six months while on supervision? If no, please indicate the date and type of violation(s) and circumstances of each.

5. Please summarize the client's performance under supervision. Please note this does not imply an endorsement or recommendation but simply a description of progress or lack thereof while on supervision. This will assist the MCB in determining if this person would be successful as a Peer Support Specialist.

Supervising Officer: _____

Supervising Officer's Signature: _____

District Office: _____

Phone Number: _____

Email Address: _____

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Criteria for Missouri Recovery Support Specialist - Peer (MRSS-P)

I. Criteria

- Minimum of HS Diploma/HSE
- Sign the Recovery Attestation Statement found on page 18 of this application
- Professional Reference Form from one of the following professionals: CADC, CRADC, CRAADC, CCJP, CRPS, MAPS, RADC, RADC-P, CCDP, CCDP-D, LPC, LCSW, Licensed Psychologist, or Director of a certified recovery support program.
- The training requirement is a total training program of 46 hours of live training broken down into 10 training categories. Some training categories may have trainer requirements and all training categories have training principles.
- Trainings may be obtained in one of the following 3 ways:
  1. MCB approved MRSS/MRSS-P/CRPR training agency
  2. U.S. Department of Education accredited program
  3. A MRSS/MRSS-P/CRPR applicant may pay an additional $10 application fee to have training certificates approved from training sources other than A or B above. An applicant must provide the power point or other material from the training to verify the trainer requirements and training principles were met. (The exception is that an applicant does not have to pay to have a MHFA training certificate accepted)

MRSS/MRSS-P Trainer Requirements & Training Principles

Recovery Oriented System of Care Training (ROSC) - 6 hours

1. Trainer Requirements
   A. No specific requirements
2. Training Principles
   A. Discussion of all Pathways to Recovery
   B. Guiding elements of a ROSC
   C. Attendees construct a ROSC diagram for their community
   D. A comparison of an Acute Model of care to a Recovery Management Model of care
   E. An overview of the state system of treatment/recovery including the various roles for Peers

Recovery Communication- 4 hours

1. Trainer Requirements
   A. Required – Personal SUD Recovery
2. Training Principles
   A. The importance of recovery language and matching language to environment
   B. Attendees should practice telling their recovery story
   C. Show Anonymous People video
   D. Discuss the importance and avenues of advocacy
   E. Encourage membership and involvement in Missouri Recovery Network

Culturally Informed -2 hours

1. Trainer Requirements
   A. No specific requirements
2. Training Principles
   A. General overview so attendees understand the concept of cultural competence
   B. Attendees understand the importance of increasing their awareness & knowledge of the cultures of their clients

MHFA Training -8 hours

1. Trainer Requirements
   A. MHFA Trainer

Recovery Support Ethics – 6 hours

1. Trainer Requirements
   A. Required – Credentialed or Licensed Professional
   B. Preferred – Personal SUD Recovery
   C. Preferred – MRSS/MRSS-P Credentialed
2. Training Principles
   A. The trainer should go through the MRSS & MRSS-P ethics codes
   B. Discussion should include real life ethical examples/case studies

Recovery and Relationships -6 hours

1. Trainer Requirements
   A. Preferred – Personal and/or Family SUD Recovery
2. Training Principles
   A. Overview of family roles & the idea of addiction as a family disease
   B. Communication skills
   C. Problem solving skills
   D. Conflict resolution skills
   E. Discussion of compassion fatigue/burnout & the importance of self-care
   F. Discussion of how to establish & build trusting relationships
   G. Attendees should practice communication skills, problem solving skills & Conflict resolution skills during training

Spirituality and Recovery -4 hours

1. Trainer Requirements
   A. No specific requirements
2. Training Principles
   A. Recognition of a holistic approach to recovery (mind, body & spirit)
   B. Relation of spirituality to recovery
   C. Discussion of finding meaning & purpose in life
   D. Discussion of employment and educational goals
   E. Understand of terms like spirituality & religion and how they are similar and how they are different
   F. History of Faith based involvement in the United States recovery movement

MI/Stages of Change -6 hours

1. Trainer Requirements
   A. No specific requirements
2. Training Principles
   A. Overview of the Stages of Change model
   B. Overview of the 8 Motivational Interviewing guiding principles
   C. Attendees should practice the 8 MI guiding principles

Co-Occurring Disorders -2 hours

1. Trainer Requirements
   A. Required – CCDP/CCDP-D Credentialed or Licensed Professional
2. Training Principles
   A. Overview of Co-Occurring Disorders including Trauma Informed Care

Medication Assisted Recovery – 2 hours

1. Trainer Requirements
   A. Required – Credentialed or Licensed Professional
   B. Preferred – MARS Credentialed
2. Training Principles
   A. Overview of current FDA approved medications being used to treat substance use disorders
   B. Provide attendees with the document "Know Your Rights"

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CHECK LIST FOR MRSS-P APPLICATION

1. You have submitted a $75.00 check with this application or have provided your credit/debit card information on page 13 of this application packet. **Applications will not be reviewed until payment is received.**
2. You have completely filled out the application.
3. You have signed the Code of Ethics.
4. You have filled out the Family Care Safety Registry Worker Registration Form and included the form with your packet. If your agency has conducted a FCSR background check on you within the last 30 days, you may submit the results to help expedite the application process.
5. You have signed the recovery attestation statement.
6. The appropriate certificates were sent to verify the required educational/training hours.
7. The appropriate High School/HSE or College transcripts were sent.
8. The Reference Form has been filled out by a Qualified Professional Reference and been mailed to the MCB.
9. If you are under court or DOC supervision, you have already obtained an exception letter from the MCB office and are including a copy of the letter with your application.

MRSS-P Domains Defined

Recovery Mentoring/Coaching:

1. Serve as a role model to a consumer in recovery
2. Establish and maintain a peer relationship
3. Teach life skills
4. Assure consumers know their rights and responsibilities
5. Teach consumers how to self-advocate

Recovery Support Services:

1. Help the consumer identify options to achieve recovery goals
2. Help the consumer develop problem solving skills
3. Help the consumer access the services of substance abuse professionals when needed to sustain their recovery
4. Help a consumer identify their strengths and how to use those strengths to maintain recovery

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Application Instructions:

1. Requirements to receive this credential are subject to change without notice. Please make sure you are submitting the most recent application packet. If you are unsure, contact the MCB office.
2. The application must be typed or neatly printed.
3. Please keep a copy of all materials submitted for your records.
4. FEES: The total MRSS-P Fee is $75.00. You may pay by check, money order, or provide credit card information on page 13 of this application packet. **Applications will not be reviewed until payment is received.**
5. Please be aware that should your application be reviewed and additional information is requested to complete the application, you will have 90 days to provide the requested information. Failure to do so will result in your application expiring without being approved.
6. All fees are non-refundable. If your application is denied or expires, fees will not be refunded.
7. If your application is denied, you may contact the MCB office staff for instructions on how to appeal the denial of your application.
8. All materials submitted to the MCB office become property of the MCB.
9. The applicant must currently reside and/or work/volunteer in the State of Missouri at least 51% of the time. The only exception to this is applicants living and working in a state that is not a member of the International Certification and Reciprocity Consortium.
10. If at any time during the credentialing process, a question arises about an applicant's moral character, reputation for honesty, integrity, or professionalism, the Board may either deny the application at that time or place the application on hold until an investigation has been completed and a decision made regarding the question brought up.
11. Please remember that it is your responsibility to keep the MCB office informed of any personal informational changes such as address and phone number changes. If you fail to notify us of changes, you will be responsible for any material that is mailed to the wrong address and will have to pay a fee to have the material sent again.
12. **Please <u>mail</u> your application to the MCB. Please do <u>not</u> fax your application.**

Important Notice To Applicants

According to Missouri Credentialing Board (MCB) Policies and Procedures, the following rules apply to those seeking a MCB credential.

1. No individual currently under any type of court supervision can apply for a MCB credential unless you have applied for and been granted a MCB exception.
2. The following items disqualify an individual from ever being credentialed with the MCB:
   A. Is listed on the Department of Mental Health disqualification registry
   B. Is listed on the employee disqualification list of the Dept. Health and Senior Services or Dept. of Social Services
   C. Any crime against a minor
   D. A person who has been convicted of, found guilty to, plead guilty to or nolo contendere to any of the Disqualifying Crime (s) Pursuant to Section 630.170, RSMo. The crime (s) will only disqualify an applicant if the crime (s) were a felony. Please view information about Section 630.170, RSMo on the MCB web site www.missouricb.com under the Disqualifying Crimes Link.
3. If an individual has applied for and been given an exception from the Department of Mental Health, the individual may apply for a MCB credential. Please send in proof of exception with your application.

APPLICATION

FOR

Missouri Recovery Support Specialist-Peer (MRSS-P)

Appropriate fee must be submitted with application.

MISSOURI CREDENTIALING BOARD
428 E. Capitol, 2nd Floor
JEFFERSON CITY, MISSOURI 65101

TELEPHONE: (573) 616-2300

WEB SITE: www.missouricb.com

EMAIL: help@missouricb.com

Please Mark Credit Card Type:

1. Visa _____
2. MC _____
3. Discover _____

CC Expiration Date: _____/_____

Credit Card #**:** _____-_____-_____-_____

Credit Card 3 Digit Verification Code: _____

THIS APPLICATION MUST BE TYPED OR PRINTED NEATLY

All Applications Become the Property of MCB

Applicant's Name: _____
First Middle Last Name Suffix (Jr., II)

_____
Maiden Other Names Used

Current Home Address: _____
Street/PO Box Apt. #

_____
City State Zip County

Home Telephone: _____/_____ SSN: _____-_____-_____

Work Telephone: _____/_____, Ext. _____ Cell Number: _____/_____

E-mail Address: _____

SEX: ____M ____F BIRTH DATE: _____/_____/_____

Are you currently or have you been credentialed or licensed as a Substance Use Disorder Professional by the MCB or any other state or organization? _____Yes _____No

If yes, which state/organization and when? _____

What is the type of credential/license held with the other state/organization?

_____

Have you ever been **ARRESTED** and/or **CONVICTED** of a felony? ____Yes ____No

If yes, please go to the www.missouricb.com website, print off the "Felony Offense Form", fill out the form and submit with your application. If you were convicted of a felony listed in Section 630.170 RSMo (view www.missouricb.com; Disqualifying Crimes link), you may not apply for this credential without an exception from the Department of Mental Health. **(If you have already completed the MCB Exceptions Process, you do not need to complete the Felony Offense Form)**

Have you ever knowingly been contacted by a Division of Family Services employee regarding a **CHILD ABUSE** and/or **CHILD NEGLECT** incident involving you? _____Yes _____No

If yes, please go to the www.missouricb.com website, print off the "Child Abuse/Neglect Statement", fill out the form and submit with your application. In addition, please contact the Division of Family Services at 573-751-2330 and request a report of the incident to include with this application.

Education/Degree Information

Please mark your highest level of education completed:

1. High School Diploma/HSE: _____
2. Addiction Certificate Program: _____
3. Associate Degree: _____ Degree Program: _____
4. Bachelor Degree: _____ Degree Program: _____
5. Master Degree/Higher: _____ Degree Program: _____

An applicant may document High School Diploma or HSE or College/University degree by:

1. Submitting copy of High School Diploma/HSE
2. Submitting official College/University transcripts directly to MCB
3. Submitting copy of College/University transcripts to MCB and having a MCB Qualified Supervisor sign/date the following:

(I attest that the applicant's degree listed above has been verified & the applicant has submitted unofficial transcripts with the application)
MCB Qualified Supervisor: _____
MCB Supervision Number: _____

Where Does the Applicant Currently Work?

Name of Employer:
Mailing Address of Employer Street City State Zip Code County
Name & Title of Immediate Supervisor:
Your Business Phone: Area Code/Telephone Number Extension Fax # Area Code/Telephone Number

Training Requirements

All applicants must submit proof of the following live education requirements:

A. 6 hours of Recovery Ethics
B. 6 hours of Recovery Oriented System of Care
C. 6 hours of Motivational Interviewing and/or Stages of Change
D. 4 hours of Recovery Communication
E. 2 hours of Culturally Informed
F. 2 hours of Medication Assisted Recovery
G. 8 hours of Mental Health First Aid
H. 6 hours of Recovery and Relationships
I. 4 hours of Spirituality and Recovery
J. 2 hours of Co-Occurring

Please submit appropriate paperwork verifying the training hours listed above.

Applicant's Agreement to the Code of Ethical Practice and Professional Conduct

I have read the Current MRSS-P Ethics Code as listed on the MCB web site www.missouricb.com, MCB Ethics Code Link and agree to abide by this code:

Print Name Date

Signature Date

AUTHORIZATION AND RELEASE

I hereby certify all of the information given herein is true and complete to the best of my knowledge and belief. I also authorize any relevant investigations, or the release of personal information to the Missouri Credentialing Board, its agents, or contractors pursuant to this application/renewal procedure. I understand falsification of any portion of this application/renewal will result in my being denied credentialing, or revocation of same upon discovery.

I further agree to hold the Missouri Credentialing Board and its Board Members, officers, agents, staff, peer evaluators and examiners, free from any civil liability for damages or complaints by reason of any action that is within the scope and arise out of the performance of their duties which they, or any of them, may take in connection with this application/renewal, any examination, the grades with respect to any examination, and/or the failure of the MCB to issue me said credential or renewal.

This Authorization and Release shall also apply to personal information requested by the Board at any time following credentialing in connection with any investigation concerning allegations that could lead to disciplinary action against me.

Print Name Date

Signature Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

PLEASE TYPE OR PRINT CLEARLY

SECTION A: WORKER TYPE (CHECK ONE BOX ONLY)

☐ CHILD CARE WORKER ($9.☐) ☐ PERSONAL CARE WORKER ($9.00) ☐ XX VOLUNTARY REGISTRANT

☐ ELDER CARE WORKER ($9.☐) ☐ RECIPIENT OF STATE OR FEDERAL FUNDS (☐.00) FOSTER PARENT (NO FEE)

SECTION B: IDENTIFYING DATA FOR BACKGROUND SCREENING

LAST NAME	FIRST NAME	MIDDLE NAME

MAIDEN AND PRIOR NAMES USED

SOCIAL SECURITY NUMBER *(ATTACH COPY OF SOCIAL SECURITY CARD)*	DATE OF BIRTH	GENDER	TELEPHONE NO. (OPTIONAL)
- -	/ /	☐ MALE ☐ FEMALE	( )

MAILING ADDRESS

STREET ADDRESS OR POST OFFICE BOX	CITY	STATE	ZIP CODE	COUNTY

HOME ADDRESS (if different than mailing address)

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

SECTION C: CURRENT EMPLOYER INFORMATION (IF APPLICABLE)

EMPLOYER NAME	CONTACT PERSON	PHONE NUMBER
		( )

ADDRESS	CITY	STATE	ZIP CODE

SECTION D: AUTHORIZATION TO RELEASE BACKGROUND SCREENING INFORMATION

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Futhermore, I authorized the Missouri Department of Health and Senior Services to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requestor of the FCSR for employment purposes only, as provided in 210.921, subsection 1 subdivision (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy in the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening determination.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to your designated bank account. I understand that my signature below authorized my Financial Institution to deduct this payment from my account. In the event that DHSS or its subcontractor, is unable to secure funds from your account or you provide insufficient or inaccurate information regarding your account, your obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT (REQUIRED IN INK)	DATE
	/ /

I

Submit this form with your application and a copy of your SS card. If your agency has ran a FCSR check within the last 30 days, you can submit the results with this form which may speed up the application process. By doing so, you give permission for your agency to share their FCSR results.

M

Recovery Attestation Statement

I am acknowledging myself as someone who is in personal recovery from a substance use disorder.

Print Name Date

Signature Date

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Credentialing Board

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PROFESSIONAL REFERENCE FORM

The individual completing this form should be able to provide a professional reference for the applicant. This form can only be filled out by a CADC, CRADC, CRAADC, CCJP, CRPS, MAPS, RADC, RADC-P, CCDP, CCDP-D, LPC, LCSW, Licensed Psychologist, or a Director of a certified recovery support program. This form cannot be filled out by an immediate family member. Please complete the form and mail directly to the MCB at the address listed above. All references will be kept confidential.

I. Name of Applicant: _____
II. Name of Reference (Print):_____
III. Relationship to Applicant:_____
IV. Credential or License Held If Applicable:_____
V. Reference Phone Number:_____
VI. Reference Address:_____
VII. Reference Signature_____ Date:_____

Please describe the nature of your relationship with the applicant and describe why you believe the applicant is qualified to be a Missouri Recovery Support Specialist-Peer:

_____
_____
_____
_____
_____
_____
_____
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_____
_____

Have you ever known the applicant to operate in an unethical manner while performing duties related to the field of substance use disorders and if so, please describe the behavior?

_____
_____
_____
_____
_____