ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
**Peer Support**

I. **Service Capacity**

A. Identify which of the qualification categories applies to your provision of Peer Support:

Certified Older Adult Peer Specialists (COAPS):

Supporting Older Adults Remotely (SOAR):

Peer Support Provider Agency:

For Agency Providers:
Do you contract with the Department of Mental Health to provide Peer Support?

Specify the number of employees for your Agency.

Certified Older Adult Specialists (COAPS):

1) Full Time:
2) Part Time:
3) Per-Diem:

Supporting Older Adults Remotely (SOAR):

1) Full Time:
2) Part Time:
3) Per-Diem:

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

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

| Language | # Administrative Staff (if applicable) | # COAPS | # SOAR |
|---|---|---|---|
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If there is no capacity for translation, describe your procedure for serving consumers who speak a language other than English or have specific hearing or visual needs.

D. Which of following modalities of Peer Support are offered?

☐ 1:1
☐ Support Group
☐ Both

If applicable, describe your process when arranging Peer Support in small groups.

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
# Peer Support

**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**

Describe how you ensure that individuals providing Peer Support have a Certificate of successful completion of COAPS or SOAR training.

Attach a COAPS/SOAR Certificate for each individual.

**IV. Training**

A. For Agencies employing COAPS/SOAR, describe your orientation.

**V. Supervision**

A. For Agencies employing COAPS/SOAR, describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors.

**VI. Proposed Rate Structure for Peer Support**

A. For Agencies employing COAPS/SOAR, describe rate structure for applicable service(s):
   a. COAPS:
   b. SOAR:

*Describe in detail any additional charges.*

**Provider employee who completed this form:**

Name: _____ Date: _____

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
**Peer Support**

| **EMPLOYEE Record Review** | | | | | | |
|---|---|---|---|---|---|---|
| **ASAP(s) Name & Monitor(s):** | | | | | | |
| **Provider:** | | | | **Date:** | | |
| **Employee Name:** | | | | | | |
| **Start Date:** | | | | | | |
| **Termination Date (*if applicable*):** | | | | | | |
| **Number of Reference Checks:** | | | | | | |
| **CORI Check:** | | | | | | |
| **OIG Checks: Time of Hire/Monthly** | | | | | | |
| **Job Description(s):** | | | | | | |
| **COAPS/SOAR Training Certificate: Ongoing Training Dates *(If applicable):*** | | | | | | |
| **Annual Performance Appraisal Date:** | | | | | | |
| **Comments:** | | | | | | |

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
**Peer Support**

| **CONSUMER Record Review** | | | | | | |
|---|---|---|---|---|---|---|
| **ASAP(s) Name & Monitor(s):** | | | | | | |
| **Provider:** | | | | **Date:** | | |
| **Consumer Name:** | | | | | | |
| **Authorization Referral Form:** | | | | | | |
| **ID Information: Name; Address; Phone; DOB:** | | | | | | |
| **Emergency Contact(s) & Phone:** | | | | | | |
| **Functional or Status Limitations:** | | | | | | |
| **Activities & Interactions Dates:** | | | | | | |
| **Name of Current CM/RN:** | | | | | | |
| **Service Start Date:** | | | | | | |
| **Termination Date *(If applicable):*** | | | | | | |

| **ASAP Authorization** | **Name, Address, Phone, DOB** | **Emergency Contact(s) & Phone** | **CM/RN & Phone** | **Hospital Name & Phone** | **Date of Service Termination** | |
|---|---|---|---|---|---|---|

Note: Shaded data elements are only required in the Consumer file if provider is not on Service Delivery Manager (Provider Direct). Otherwise, the agency demonstrator will be asked to illustrate "on screen."

| Name & Position of Agency Demonstrator: | |
|---|---|