



Peer Support Employment Training Program (PSETP) Application for Review and Recognition by the OIFA Alliance

The OIFA Alliance oversees the review and recognition process for Arizona’s Peer Support Employment Training Programs (PSETPs).

Providers seeking review and recognition shall submit a completed application to OIFA@azahcccs.gov with “Attn: PSETP Application” in the subject line. Upon receipt of the application, the OIFA Alliance will jointly determine a Lead to perform program reviews and approvals. The applicant will be notified within 30 days of the initial application submission by the Lead about next steps in the process.

Once approved by the OIFA Alliance, the PSETP will be recognized by AHCCCS as compliant with AMPM Policy 963. The Peer/Recovery Support Specialist (PRSS) credentials issued thereafter by the PSETP are valid for Medicaid reimbursement of peer support services delivered under supervision to eligible individuals.

PSETPs recognized prior to October 1, 2022 shall complete and submit an updated application no later than October 1, 2024

Type of submission: Initial Prior-Approval Update

PROVIDER INFORMATION

Date of Submission:

Applicant Point of Contact:

Email:

Phone Number:

Agency Information

Provider Administrative Address:

AHCCCS ID:

Date registered as and AHCCCS Provider:

Are you contracted with any of the following health plans? (Check all that apply)

- Arizona Complete Health
- Banner University Family Care
- Health Choice Arizona
- Care1st of Arizona
- Mercy Care
- Molina Healthcare
- UnitedHealthcare Community Plan
- AHCCCS Division of Fee-for-Service Management

What services are you providing?

Age groups and populations for which your agency provides services:

Please tell us about your agency culture and history:

Please describe how you will define and measure sustained recovery?

Please describe your experience in tracking, monitoring and oversight of AHCCCS and health plan policies and procedures?

Please describe how your Peer Support Employment Training Program will:

Support a competent workforce:

Be an effective peer support training program:

Hold people to the highest standards of conduct:

Stay true to the ideals and values of peer support:

Identify any specialty areas, unmet needs or special populations your PSETP will address:

Describe experience and/or credentials, certifications that your senior leadership team possesses relating to:

The practice of peer support.

Job training:

Workforce development:

Do you intend to include job shadowing or internship component as part of your training program, if so please describe:

The OIFA Alliance expects all training programs to adhere to nationally-recognized guidelines and standards of practice for peer support.

Describe how your program will follow the essence of peer support as described in nationally-recognized practice guidelines and the Arizona guiding principles

Identify additional elements that your program will include related to:

Candidate screening process

Mechanisms to monitor outcomes, to include but not limited to employment outcomes/job placement

Workforce development, career development, and readiness for employment

Please describe any experience integrating peer workers into your organization

AMPM Policy 963 requires PSETPs to utilize a standard application form (AMPM 963 Attachment B) to interview and admit potential trainees, and report graduates to AHCCCS using a standard form (AMPM 963 Attachment C)

Please attest your program will utilize these documents as required per AMPM Policy 963: Yes No

Recognized programs will notify the OIFA Alliance of any changes to the following

- Agency name, address or telephone number
- Point(s) of contact for the PSETP
- Trainers for the PSETP
- Changes in training locations

Please attest your program will notify the OIFA Alliance of any changes listed above.: Yes No

Trainer Credentials

Please provide the following information for the PSETP trainers

- | | |
|---------------|---------------------|
| 1. Last Name: | First Name: |
| Program: | Date of graduation: |
| 2. Last Name: | First Name: |
| Program: | Date of graduation: |
| 3. Last Name: | First Name: |
| Program: | Date of graduation: |

Training Locations

Please provide the following information for locations at which trainings will be held

- | | |
|-------------|-------------------------------|
| 1. Address: | |
| Phone: | Provider Type (if applicable) |
| 2. Address: | |
| Phone: | Provider Type (if applicable) |
| 3. Address: | |
| Phone: | Provider Type (if applicable) |