

Family Support Specialist Primary Certification Application

2014

Family Support Specialist Primary Certification Application
Developmental Disabilities Program (DDP)
Department of Public Health and Human Services (DPHHS)
State of Montana

Instructions:

Read and follow the instructions when applying for Primary Certification as a Family Support Specialist (FSS). Three parts are required for submission and presented below in a checklist format. DDP Child and Family Services staff reviews submitted packets for certification.

Part I – Education and Training

- Complete Sections A-C.
- Request official transcripts showing your baccalaureate degree in a human service field and are sent from colleges or universities attended directly to DDP:

Family Support Specialist Certification
Developmental Disabilities Program, DPHHS
P O Box 4210
Helena, MT 59604-4210

- Include a copy of any license or certificate which will help support your application.

Part II – Employment History

- Make additional copies of this section so each relevant employment experience in the human service field can be documented by your employer.
- Complete all sections for each employment experience including the signed **Employer Verification Signature Page**.

Part III – Letters of Recommendation

- Request two letters of recommendation from individuals with knowledge of your work experience and skills in this field and submit them to:

Family Support Specialist Certification
Developmental Disabilities Program, DPHHS
P O Box 4210
Helena, MT 59604-4210

Send all application materials to:

Family Support Specialist Certification
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Part I – Education and Training

A. Personal Information

Applicant's Name		Date	
Home Address		Work Address	
Street Address		Street Address	
City		City	
State	Zip	State	Zip
Phone		Phone	

B. Education and Training

List all education and training relevant to this application.

Name of School or Training Site	Degree/Training Received	Year

C. Certification or Licensure

Check the appropriate box if you possess **current** certification, licensure, or work experience relevant to Primary Family Support Specialist Certification.

Qualification	Montana	Other State/Country?
Licensed Psychologist		
Registered Nurse		
Member of Academy of Certified Social Workers		
Special Education Certification or Endorsement		
Early Intervention Specialist Certification		
Licensed Speech/Language Pathologist		
Licensed Audiologist		
Licensed Physical Therapist		
Licensed Occupational Therapist		
Nutritionist		

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Have you possessed relevant certification in the past? If yes, what:

Do you have other qualifications relevant to this certification?

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Name of Applicant

Part II – Employment History

Provide the information requested below to reflect current or most recent work experience. If you have more than one relevant work experience for DDP to consider, make copies of this form so each work experience is documented. After completion, send the form to the person who supervised your work (or another representative of the employer) for signature. Return the signed **Employer Verification Signature Page** with your complete application.

Employer	
Phone	
Supervisor	
Dates of Employment	
Position Title	
Full-time	Part-time
Did/does the work performed for this employer take place in an early intervention setting? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>	
How often does/did the position require you to provide direct services to children with disabilities and their families? Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Routinely <input type="checkbox"/>	
How often did/does the position require you to gather assessment information about children’s skills and behaviors? Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Routinely <input type="checkbox"/>	
How often did/does the position require you to gather assessment information about families’ concerns, wants, priorities, and resources? Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Routinely <input type="checkbox"/>	
How often did/does the position require you to develop Individualized Family Service Plans with families? Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Routinely <input type="checkbox"/>	
How often did/does the position require you to plan intervention strategies or other educational activities within the daily routine with children and families? Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Routinely <input type="checkbox"/>	
How often did/does the position require you to implement intervention programs and services with children with disabilities? Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Routinely <input type="checkbox"/>	
How often did/does the position require you to implement educational activities and services with families? Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Routinely <input type="checkbox"/>	

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How often did/does the position require you to coordinate community services and other resources?
Never Occasionally Routinely

How often did/does the position require you to provide direct services *by yourself* to children with disabilities and their families?
Never Occasionally Routinely

How often did/does the position require you to provide direct services *as a part of a team* to children with disabilities and their families?
Never Occasionally Routinely

List other major job duties and the percent of your time engaged with those duties:

Describe briefly, in narrative form, the nature of the work you performed/are performing for this employer or attach a position description for your current position.

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Name of Applicant

Employer Verification Signature Page

To the Employer: The person named above is an applicant for Primary Certification by the State of Montana as a Family Support Specialist. Rules and Regulations dictate family education and support services for children with disabilities and their families are provided by qualified personnel who meet the highest requirements of the State for a Family Support Specialist. Your signature below indicates you have read the information provided by the applicant and that you verify the employment information provided by the applicant is true to the best of your knowledge.

Signature of Employer _____

Print Name _____

Title _____

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Name of Applicant

PART III – LETTERS OF RECOMMENDATION

To the Writer: The person named above is an applicant for Primary Certification by the State of Montana as a Family Support Specialist. Rules and Regulations dictate family education and support services for children with disabilities and their families are provided by qualified personnel who meet the highest requirements of the State for a Family Support Specialist. Your letter of recommendation should address your direct knowledge of the applicant's knowledge, skills, and work experiences relevant to providing family education and support services to children with disabilities and their families. Letters should be sent directly from the writer to the address below.

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Developmental Disabilities Program, DPHHS
P O Box 4210
Helena, MT 59604-4210**