PROVIDER	PROVIDER ID	SERVICING COUNTY	GEOGRAPHIC SERVICE AREA (GSA)	PEER AND RECOVERY SUPPORT SERVICES (PRSS) LAST NAME	PRSS FIRST NAME	PEER SUPPORT EMPLOYMENT TRAINING PROGRAM	DATE CREDENTIALED	DATE EMPLOYED WITH PROVIDER	END DATE	BEHAVIORAL HEALTH WORKER CATEGORY	SUPERVISION	CONTINUING EDUCATION AND ONGOING LEARNING	~~FULL TIME EMPLOYMENT~~ COMPLETED REQUIRED TRAINING (PSYCHOSIS & ANOSOGNOSIA)	CONTRACTOR AND FFS PROGRAMS ONLY	
														CONTRACTOR / FEE-FOR-SERVICE (FFS) PROGRAM	~~LINE OF BUSINESS/CONTRACTOR ONLY~~
The provider employing the PRSS	Employer's AHCCCS Provider Identification Number	The county in which the PRSS is employed	The GSA in which the employer is located (Enter as: Northern, Central or Southern)			Name of the training program issuing the PRSS credential. *(i.e. Name of the issuing agency/program on the certificate)*	Enter as: MM/DD/YYYY *(Column set to date)*	Initial start date - Enter as: MM/DD/YYYY *(Column set to date)*	Discontinuation of employment occurring during the reporting period. Enter as: MM/DD/YYYY If not applicable, leave blank. Do not enter "N/A" *(Column set to date)*	Is the employee a Behavioral Health Professional (BHP), Behavioral Health Technician (BHT) or Behavioral Health Paraprofessiional (BHPP)	Did the PRSS receive supervision during reporting period? Y or N?	Hours of continuing education and ongoing learning relevant to peer support obtained during the reporting period.	Has the PRSS completed the required training? ~~Is the PRSS employed at 32+ hour/week?~~ Y or N	The name of the Contractor or ffs provider submitting this report	~~All Contractor Line(s) of Business for this report. Use abbreviations in Naming Instructions (ACC, ACC-RBHA, ALTCS E/PD, DDD)~~