



**STATE OF TENNESSEE  
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES  
OFFICE OF STATEWIDE SYSTEMS OF CARE  
Andrew Jackson Building, 5<sup>th</sup> Floor  
500 Deaderick Street  
NASHVILLE, TENNESSEE 37243**

## **Certified Family Support Specialist Statement of Support**

The person named below is completing an application to be certified as a Family Support Specialist. All applicants must submit (3) three statements of support in order to complete the application process. You have been chosen by the applicant to provide a statement for this purpose. Once the statement of support is completed, place the form in an envelope, seal the envelope, sign the seal of the envelope with your signature, and return the envelope to the applicant so it can be submitted with the application. We appreciate your support of this applicant. If you have questions, please contact the Office of Statewide Systems of Care or Melissa McGee at 615-253-4160 or [Melissa.McGee@tn.gov](mailto:Melissa.McGee@tn.gov).

- 1) Prospective Certified Family Support Specialist:

\_\_\_\_\_

**(Please Print Name)**

- 2) Please describe your knowledge of the applicant's ability to work in the role of a Family Support Specialist:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3) Please describe the nature of your relationship with the applicant (personal or professional):

---

---

---

---

---

---

4) Please describe the strengths and any potential weaknesses of the applicant in their ability to provide services as a Family Support Specialist :

---

---

---

---

---

---

---

---

**Supporter Contact Information**

*(Please Print)*

Name \_\_\_\_\_

Agency \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Email \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**My signature below affirms that all of the information contained in this document is true, and that I support this application.**

\_\_\_\_\_  
Signature of Supporter

\_\_\_\_\_  
Date