AspireHopeNY, Inc.
REFERRAL FORM

Submit COMPLETED form to:
AspireHopeNY, Inc.
25 W. Steuben St.
Bath, NY 14810
Phone: (607)776-2164
Fax: (607) 776-4327
Email: referral4services@aspirehope.org

Date: ____________________

REFERRAL SOURCE

☐ SELF: ______________________________ (Name)

Phone #: ____________________ Email: ______________________________

How or from whom did you hear of our agency? ______________________________

☐ AGENCY: ______________________________ (Agency Name)

Contact Person Name: ____________________ Phone #: ______________ Ext. ________

Email: ______________________________

☐ OTHER: ______________________________ (Name)

Contact Person Name: ____________________ Phone #: ______________ Ext. ________

Email: ______________________________

INDIVIDUAL BEING REFERRED: Check One ☐ Child (Ages 0-12yrs) ☐ Youth (Ages 13-21) ☐Adult

Name: ____________________ Date of Birth: ____________ Gender ID: ______________

** *If under age 18*, Legal Guardian: ______________________________

***Caregiver* (if different from Legal Guardian): ______________________________

Address: ______________________________ (Street) (City, State, Zip) County: ______________

Phone: ____________________ Cell: ________________ Email: ____________________

TO BE COMPLETED BY THE INDIVIDUAL BEING REFERRED: (REQUIRED)

I give my permission for personnel of the referring agency and AspireHopeNY, Inc., to give and receive information (i.e.: Family, educational, and medical information). I understand a representative from AspireHopeNY, Inc. will contact me within 10 business days from the time they receive my information to discuss these services.

Individual Signature:______________________________ Date: ______________

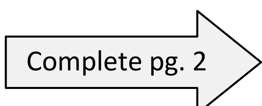
** ***If under age 18:***
Legal Guardian Signature: ______________________________ Date: ______________

****To be completed by the REFERRAL SOURCE if the Individual is UNABLE to sign: (REQUIRED)**

Verification of Services request

I, ____________________ (Name), ____________________ (Title), from ____________________ (Agency),

verify that I have verbally spoken with the above named individual to confirm that the information above is accurate and has been requested by the individual on ____________________ (Date).



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PROGRAM / SERVICES SOUGHT: *(CHECK APPROPRIATE BOXES)*

☐ **Family Support Services (FSS)**
This service is provided to parents and legal guardians by a NYS credentialed Family Peer Advocate (FPA) having 'lived-experience' as the parent (biological, foster, adoptive) or primary caregiver of a child/youth with a social, emotional, behavioral, mental health, or developmental challenge. Our FSS program includes advocacy, education, information & referral, family to family support, and respite. A required assessment of the Family's Needs and Strengths (FANS) will be completed by the family throughout an average 18 month length of service.

☐ **Youth Program (Ages 13-21)**
Our Youth Program is youth-led, designed to empower & to encourage youth to engage in healthy decisions! Through our peer-to-peer support groups, events and activities we provide youth with a chance to network with their peers.

☐ **Southern Tier Transformation Plan (STTP) in Partnership with Elmira Psychiatric Center**
(Peer Training Conferences are offered throughout the year for advocates, peers and professionals.)
☐ *Regional Support groups are peer led with therapeutic professional support providing a psycho-educational model of support to the family members of loved ones with mental health challenges.*
☐ *ACT/Lite/MIT Peers assist individuals in linking support services, pre-vocational options employment, housing and peer support*

☐ **Adult HCBS**
Adult HCBS-In collaboration with HHUNY and Health Home Care Management: provides Family Support and Training, Education Support Services, Pre-vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment.
Include with Referral Form (required to complete referral): ☐ ***Plan of Care*** ☐ ***Insurance Authorization***

☐ **OPWDD In-Home Respite**
This program provides a break for the parent/guardian of a child with OPWDD Waiver Eligibility. Necessary paperwork completed by outside agency. Once approved, a minimum 3 hour block of respite monthly is available.

☐ **OPWDD Recreation**
This program provides no cost activities for individuals 21 years and under with developmental disabilities, their siblings and parents/guardians. Staff provides hands-on support to families and transportation assistance to events. –Must be OPWDD Eligible with necessary paperwork competed by outside agency.

** **OMH Waiver**
The waiver program is intended to "wrap" services and supports around a child and family. Through collaboration and coordination families have access to expert staff who specialize in particular areas addressing their unique needs. ***Referrals for these services go through SPOA.***

** **Bridges to Health (B2H)**
This program provides opportunities for improving the health and well-being of children in foster care or Community Services supervision. Services are provided to the child, family and caregivers, including birth, foster and adoptive parents and siblings. ***Referrals for these services go through OCFS or LDSS.***

** **Steuben Diversion**
This program provides services to families receiving Steuben County Mental Health Services only. ***Referrals come directly from Steuben County Mental Health Therapists****. Respite/Skill Building and Family Support Services are provided to families for a duration of up to 12 weeks.*

Date Entered into AWARDS: ______________________ Initials: __________