ESPERANZA

Independent and Supported Living Services

1000 South Fremont Avenue, Suite 1110,
Unit 33, Alhambra, CA 91803

REFERRAL FORM
RISE Program

Referral Date_____

Child's Information:

Name_____Gender_____ DOB_____
Home Address_____City_____Zip_____
School_____City_____Grade_____
Preferred method of Contact? □Cell phone#_____ □email _____□through parent
Language spoken at home_____ Preferred Language_____
Does the child have siblings (if so, how many w/ages):_____

How did you hear about our program?_____

Reason for Referral:

Concerns pertaining to:

□ Academics
□ Social Behavior
□ Psychological/Physical Health
□ Family Dynamics
□ Needs Mentoring
□ Other_____

Additional Information_____
_____
_____
_____

Parent's Information:

Parent/Legal Guardian(s)_____ Contact #_____

Parent has a verifiable disability as determined by your agency □yes □ No □ Decline to State
Please note: The RISE program is funded for children whose parents have a verifiable disability. Parents may be required to show disability verification.

Family Information:

Services Family is currently receiving: (check all that apply)
□ Department of Mental Health (DMH)
□ Department of Public Social Services (DPSS)
□ Social Security Administration (SSA)
□ Department of Rehabilitation (DOR)
□ Regional Center
□ Housing Assistance
□ Cal Works/TANF
□ Other: _____

Disclosure/Consent for Contact:

I,_____ give consent for Esperanza Services to contact me with information of the services available for my child.

_____/_____
Signature Date

Referred By: _____ Address: _____
Name of Organization
Contact Name _____ Contact email: _____

Contact Telephone _____

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

I hereby authorize Esperanza Services staff to exchange any data pertaining to my disability (ies) requested by the agencies, companies or persons indicated below in efforts for my child to be eligible for the program. Data transmission may be in oral, written, fax or electronic format.

INITIAL: (all that apply)

_____Referring Agency_____Telephone_____
Contact Name _____

_____Department of Mental Health (DMH)
Contact Name _____Telephone_____

_____Department of Public Social Services (DPSS)
Contact Name _____Telephone_____

_____Social Security Administration (SSA)
Contact Name _____Telephone_____

_____Department of Rehabilitation (DOR)
Contact Name _____Telephone_____

_____Regional Center
Contact Name _____Telephone_____

_____Doctor or Therapist:

Name_____ Telephone_____
Name_____ Telephone_____
Name_____ Telephone_____

_____Other: _____
Contact Name _____Telephone_____

NAME:_____

SIGNATURE:_____DATE:_____

Please Note: This consent will remain valid until it is rescinded in writing.

I hereby withdraw the above consent for release of information to_____
SIGNATURE:_____DATE:_____

Referred By: _____ Address: _____
Name of Organization
Contact Name _____ Contact email: _____

Contact Telephone _____