☐ Adult	☐ Youth

Last Name Referring Counselor Details		
First Name	Phone	Agency
Email		
Last Name Peer Details		
First Name	Phone	Date of Birth
Email		
Gender ☐ Male ☐ Female ☐ Trans ☐ Non Binary ☐ Prefer not to say		
Race/Ethnicity ☐ American Indian ☐ Asian/Pacific Islander	☐ Black/African American ☐ Hispanic	☐ White/Caucasian ☐ Multiple/Other_____
Language Preference		

Briefly describe the reasons for requesting a peer support specialist and specific tasks you need assistance with. In what ways could this peer benefit from Peer Support Services?

Please provide a summary of the behavioral/mental health conditions and challenges you are experiencing. Please provide any additional pertinent information you feel would be helpful in matching up you with a peer support specialist. We want the relationship to be supportive and meaningful.

Please list the number of hours per week that would be helpful to your client. Maximum 5 hours peer week

Hours ☐1	☐2	☐3	☐4	☐5

Email For Youth Referral		
Parent Name		Phone

Send all referrals to: peer-support@treeofhopeassn.com