SUPER SIBLINGS ARE US!

Getting along with a sibling may be difficult at times, but getting along with a sibling who has a disability may be a real challenge!

Do you sometimes feel embarrassed? Sad? Angry? Confused?

Do you feel guilty about your feelings?

Do you find it hard to talk to your parents, friends and teachers about your feelings?

Would you like to share your feelings, concerns and also meet new friends and have some fun?

Come and join

SUPER SIBLINGS ARE US!

We are just a phone call away!

~No Fee~

For information contact

Natasha Tomlins

(845)342-2400 ext. 254

ntomlins@mhaorangeny.com

SUPER SIBLINGS ARE US!

Monthly Workshops for Siblings of Children with Special Needs

We're the very special brothers and sisters of individuals with developmental disabilities.

Mental Health Association in Orange County, Inc.
73 James P. Kelly Way
Middletown , NY 10940

Office: (845) 342-2400 Fax: (845) 343-9665
24 hr. Helpline/Rapeline 1-800-832-1200

The Sibling Project of the Mental Health Association in Orange County, Inc. is funded through a family support grant from the Office of People with Developmental Disabilities (OPWDD) and in contract with the Hudson Valley DDSO.

SIBLING PROJECT GOALS

Activities are designed to reflect sibling concerns. The goals are to provide siblings with an opportunity to meet other siblings in a relaxed, recreational setting, an opportunity to discuss common joys and concerns with other siblings and to learn how others handle situations commonly experienced by siblings of children with developmental disabilities.

To register complete items ***1 through 4.***

1) Completed application form, printed clearly!
2) Sign dated photo release form.
3) HIPAA ("Notice of Privacy Practices" found on MHA's website) signature page filled out, signed and dated. www.mhaorangeny.com (last button on at bottom of navigation bar.)
4) Notice of Decision from Hudson Valley DDRO.

OPWDD ELIGIBILTY REQUIRED- Notice of Decision from Hudson Valley DDRO. Call 845-342-2400 Ext 253 for eligibility requirements.

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REGISTRATION FORM

SUPER SIBLING(S)

Name _____ Birth date _____

Name _____ Birth date _____

Name _____ Birth date_____

Parent/Guardian

Name _____

Address _____

_____ _____ _____

Telephone _____**(home)** _____**(cell)**

Person(s) with a disability

Name_____ Birth date _____

Social Security # _____ - ____ - _____ Tabs # _____

Disability/diagnosis _____

Person(s) with a disability

Name_____ Birth date _____

Social Security # _____ - ____ - _____ Tabs # _____

Disability/diagnosis _____

Mail to:
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