



Coalition of Agencies in Service to the Elderly Bio Information Form

Date: **August 16, 2017**

Name: **Ronald Fernandez**

Title: **Director/RRDS**

Agency Name: **Headway of WNY/ Regional Center TBI and NHTD Waiver**

Complete Mailing Address: **2635 Delaware Ave. Buffalo NY 14216**

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Email address: **RFernandez@headwayofwny.org**

Website address: **www.Headwayofwny.org**

What age range do you serve? **Starting at 18 no age cap**

A brief description of your position: **Director of Headway which is the regional center for the TBI and NHTD Waiver Programs**

A brief description of what your agency does: **Administer the NHTD and TBI waiver programs in 6 Western NY Counties including Niagara. Provide support group services for people and families with TBI. Provide advocacy services for individuals, families and Veterans dealing with cognitive problems. Provide educational events for the community. Provide memberships for those interested in furthering our mission and wish to be involved in its implementation. Provide volunteering opportunities.**

Please list any other programs your agency provides: