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A program of Center for Family Life and Recovery, Inc.

Adult Referral Form

The Compeer Program recruits, screens and matches trained volunteers in one–to-one friendship relationships with adults receiving mental health treatment. Community volunteers agree to a one-year commitment with visits of at least 4 hours per month. Individuals are referred by mental health professionals including, therapists, social workers, or caseworkers. All information is requested to ensure, to the greatest degree possible, the success of the match; because of this a signed release form must accompany all referrals. All answers are kept confidential.

Name:

Address:

City, State, Zip:

E-mail:

County: Phone:

Type of Residence: ____Own home/apt. ____Group Home ____Nursing/HRF ____Family care ____Shelter ____Hospital ____Other_____

If currently hospitalized, specify unit:

Projected discharge date:

Referred By:

Job Title:

Agency:

Address:

Email:

Phone: Fax:

Date Referral Received by Compeer Staff:

Date of Birth: Gender: Male Female

Race: ___African American ___Asian ___Bosnian ___Caucasian ___Hispanic ___Native American Other:_____

Primary Family Contact:

Relationship to Referred:

Address of Family Contact:

Phone:

Occupation of the Referred:_____
___Student ___Homemaker ___Veteran ___Retired ___SSI ___Other_____

Place of Employment:_____

Has the Compeer Program been discussed w/ the referred? Yes No

Diagnosis*:_____ ___ ___ ___.___ ___

*Must have a primary diagnosis of Mental Illness in order receive Compeer services

Hx of Hospitalization:_____ Dates:_____

Reason(s) for Referral:_____

_____

_____

_____

Which services would the Referred be interested in? (Check all that apply)

_____1:1 match _____Pen Pals _____E-Buddies _____Coffee Club _____Compeer Calling _____Skill Builders

List the goals you have for the Referred:

1. _____
2. _____
3. _____
4. _____

Please list the interests, skills, strengths, hobbies, social clubs, programs and attributes of the referred (to best match the referred, please be as specific as possible):

_____
_____
_____
_____

Please list any medical conditions of the referred (include special needs, dietary restrictions, allergies, physical disabilities, medications etc):

_____
_____
_____
_____

Please list risk behaviors/symptoms of the referred (What does the volunteer need to know? Include behavioral issues, hx of substance abuse, hx of abuse or neglect, compulsive behaviors, fluctuations in mood, hallucinations, suicide, etc.):

_____
_____
_____
_____
_____
_____

Please indicate if the referred have any definite personal preferences regarding his/her volunteer? NOTE: It is Compeer's policy to match same gender individuals:

_____
_____
_____

What is the last level of education completed by the referred? (Check the last level completed)
_____Grade School _____High School _____Voc/Tech/Trade _____Undergraduate _____Graduate _____Unknown

Does the referred smoke? ____Yes ____No Does the referred object to a volunteer that smokes? ____Yes ____No

Does the referred have use of a car? ____Yes ____No
Does the referred use public transportation? ____Yes ____No ____Needs Assistance

Specify when the referred is available (Check all that apply): ____Daytime ____Evenings ____Weekdays ____Weekends ____Holidays

If there are any constraints/restrictions to availability, please specify:_____
_____

Additional Comments/Suggestions:

_____
_____
_____
_____

How did you learn of Compeer? ____T.V. ____Newspaper ____Agency ____Colleague ____Client ____Brochure/Poster ____Other

Primary Clinical Provider/Therapist/Practitioner (if different from the referring person):

Agency: Phone:

Address: Best Time To Call:

As the referring person, I agree to follow the guidelines of the Compeer Program, and be available to the Compeer staff, and volunteer as needed, in order to best serve the referred individual. X_____ Date:_____
(signature of referring individual)

1. Gender:

___Male
___Female

2. Ethnic Origin: *(check one)*

__ White
___Black-Unspecified Origin
___African-American
___Black-of Jamaican Origin
___Black-of Other Origin
___Hispanic-Unspecified Origin
___Hispanic-of Puerto Rican Origin
___Hispanic-of Central American Origin
___Hispanic-of Other Origin
___Asian/Pacific Islander- Unspecified Origin
___Asian/Pacific Islander-of Chinese Origin
___Asian/Pacific Islander of Indo-Chinese Origin
___Asian/Pacific Islander of Indian/ Pakistani Origin
___Asian/Pacific Islander-of Other Origin
___Native American
___Bi-Racial _____
___Unknown / Other _____

3. Type of Residence: *(check one)*

___Own Residence
___Rental Home/Apartment
___Home of Parent, Relative, or Friend
___Rooming House, Hotel, SRO
___Nursing/Health-Related Facility
___Institution
___Community Residence
___Adult Home (PPHA)
__Family Care
__Incarcerated (prison, jail, lock-up)
__Foster Home (C&Y clients)
___Therapeutic Foster Home
___RTF (C&Y Clients)
___Transient/Homeless
___Other
___Unknown

4. County of Residence: *(check one)*

___Oneida
___Herkimer
___Other NY County
_____
(specify)

5. Marital Status:

___Never Married
___Married
___Widowed
___Separated
___Divorced/Annulled
___Unknown

6. Education: *(check last grade completed)*

___No Education
___Less than high-school
___Some high school (8th grade or less)
___High-school/GED diploma
___Vocational,technical, business school
___Some college
___2 year college degree
___4 year college degree
___Graduate school
__Unknown

7.Household Composition: *(check one or more)*

___With Parent(s)
___With Siblings
___With Spouse
___With Children
___With Other Relatives
___In Institution
___In Residence Facility
___No Permanent
___Unknown

8. Religion: *(check one)*

___Roman Catholic
___Protestant
___Baptist
___Pentacostal
___Methodist
___Jewish
___Islam
__Buddhist
___Hindu
___Christian Scientist
___Jehovah's Witness
___Other
___Unknown
Congregational Affiliation:_____
(Please specify)

9. Primary Language

___English
___Spanish
___Vietnamese
___Sign
___Braille
___Other
___Unknown

10. Income Source: *(check largest single source)*

___Tanif
___ SSI
___SSDI
___Other
___Unknown
____Medicaid
____ Medicare

11. Additional Disabilities: *…Please Explain*

___No Disabilities
___Developmental:_____
___Mental Retardation:_____
___Alcohol:_____
__ Drugs:_____
___Mixed Substance:_____
___Blind:_____
__Hearing Impaired:_____
___Ambulation Impairment:_____
___Other:_____
___Unknown

12. Prior Mental Health Service: *(check one)*

___No Prior Known Services
___Prior Inpatient
___Prior Outpatient
___Prior Day Program
___Inpatient & Outpatient
___Inpatient Day Program
___Inpatient, Outpatient, Day Program
__Unknown

13. Annual Income

__Less than $20,000

___$20,000 to $34,999

___$35,000 to $49,999

___$50,00 to $74,999

___$75,000 and over

Waiver of Liability

It is the purpose of this agreement to exempt, waive and relieve Compeer, Inc., its affiliate associations, event hosts, sponsors, and each of them, their officers, directors, agents and employees, hereinafter referred to as 'releases,' from any and all liability for personal injury, property damage, and wrongful death, including if caused by negligence--including the negligence, if any, of releases.

Participant (and the parent(s) or legal guardian(s) of participant, if applicable) acknowledges they have read and understand the foregoing.

_____	_____	_____
Participant Signature	Age	Date Signed
_____		_____
Participant Name (Print)		Witness (Therapist)
_____		_____
Parent or Guardian Signature		Date Signed

Note: Please feel free to attach additional information.

If you would like to discuss this application or require further information, please contact Brandi Lyons at 315.733.1709.

Release of Information Consent/Authorization Form

I hereby give permission and consent for this agency, listed below, to periodically send and discuss information about myself, or the minor named in this form, which may include PHI (protected health information) and give authorization for this agency, to release all necessary information to appropriate staff of Compeer for the purpose of helping the Compeer Program in providing a supportive friendship/mentoring match.

I understand that this information will be kept at the Compeer office. Furthermore, I understand and agree that not only will Compeer staff have access to this information, but I am also aware that information may also be shared with college students who may serve an internship in this agency. In addition, information will also be shared with potential and current Compeer volunteers as needed to further the success of a potential and present match. I understand that Compeer staff, volunteers and interns will be allowed to discuss information with the referring agency and their representative as needed.

I understand that I have the legal right to refuse to give PHI to any agency, and or person I so designate provided the request for denial is clearly written and provided to Compeer along with this release of information authorization. This release of information is valid for the period that I am receiving Compeer services.

_____

(Name of agency releasing information on behalf of consumer)

_____ _____ _____ _____

(street address of agency) (city) (state) (zip)

_____ _____ _____

(phone) (ext.) (fax)

_____

(name of consumer whose information is being released)

_____ _____ _____

(signature of consumer or legal guardian authorizing release) (printed name of consumer or legal guardian) (date)

_____ _____ _____

(signature of witness - preferably agency representative) (printed name of witness) (date)

Note: This consent for authorization may be withdrawn at any time by the consumer or legal guardian through written notification and forwarded to the Compeer office. Consent for authorization will also expire when referred consumer is no longer receiving services from the Compeer program.

In accordance to the New York State Mental Health Law, consumer files will be kept for seven years. If at that time the consumer is not receiving services from Compeer, the file will be destroyed.

Compeer PROGRAM
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REFERRAL GUIDELINES

Compeer volunteers are screened, trained and supported to offer regular individual social activities and support with approved clients for an hour a week for a minimum twelve-month period. The friendship can be a valuable adjunct to your therapeutic interaction with clients who both require and could benefit from a supportive friendship and social re/connection.

PLEASE NOTE:

- All information requested is essential to facilitate the matching process and is confidential. You are welcome to make copies of the enclosed referral form for future use.

- Positively reflecting the client's personality (e.g. appreciative, likeable, easy to talk to etc.), as well as demonstrating a need and desire for a volunteer, can enhance a client's chance of being matched with a volunteer.

- Pertinent information both psychiatric and medical should always be disclosed – either on the referral form or in conversation with the Compeer Adult Coordinator.

- Because of the high demand for Compeer volunteers, we cannot say <u>if</u>, or <u>when</u> a client will be matched, as some referred clients never receive a Compeer friend.

- **Please help us by only referring those clients who are most suitable and most in need. Please ensure that your client understands that there may be a long waiting period and there is a chance that we may not find them a suitable volunteer.**

- Referring Professionals play an important role in choosing a volunteer and supporting the Compeer relationship as it develops. You are the primary contact for issues regarding your client. In your role of monitoring the friendship, you:
  - Ask your client about their Compeer activities during your regular consultations
  - Are available for the volunteer to discuss any concerns regarding your client
  - Contact the volunteer or Compeer to ask how things are going
  - Receive copies of the volunteer's monthly report (if requested in writing)
  - Will be contacted by Compeer staff if concerns arise
  - Complete an Annual Survey of each client regarding Compeer services
  - Notify Compeer of any changes for the client (e.g.: contact information, health information, changes in services, address, phone number, email, diagnosis, etc.).

  Please ensure that you have the time to fulfill these responsibilities before making the referral.
- As the primary support system for the volunteer, Compeer will:

- Contact the volunteer after the first meeting (match date) and regularly throughout the friendship to monitor and support the match
- Provide support and guidance during office hours
- Require written monthly reports from volunteers