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<http://www.whenthereshelpthereshope.com>

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.

Date Referral Received by Compeer Staff: \_\_\_\_\_

Name: Address: City, State, Zip: E-mail: County:                      Phone:	Date of Birth: _____	Gender: Male    Female
	Race: African American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other: _____	
Type of Residence: ___ Own home/apt. ___ Group Home ___ Nursing/HRF ___ Family care ___ Shelter ___ Hospital ___ Other _____ If currently hospitalized, specify unit: Projected discharge date:	Primary Family Contact: Relationship to Referred:	
	Address of Family Contact:  Phone: _____	
Referred By: Job Title: Agency:	Occupation of the Referred: _____ ___ Student ___ Homemaker ___ Veteran ___ Retired ___ SSI ___ Other _____	
	Place of Employment: _____	
Address: Email: Phone:                      Fax:	Has the Compeer Program been discussed with 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    \_\_\_ E-Buddies    \_\_\_ Enrichment activities (adult groups)

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?  Social Media  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)

Use the following table to determine income level. Use worksheet on next page.

Figure 1 - 2019 Income Limits Based on HUD Area Median Income(AMI) for Utica-Rome Metro Area				
Household Size	Household Income Category (%AMI)			Area Median Income (AMI)
	Extremely Low (< 30%)	Very Low (< 50%)	Low (< 80%)	
1 Person	\$ 14,800	\$ 24,650	\$ 39,450	
2 Person	\$ 16,910	\$ 28,200	\$ 45,050	
3 Person	\$ 21,330	\$ 31,700	\$ 50,700	
4 Person	\$ 25,750	\$ 35,200	\$ 56,300	
5 Person	\$ 30,170	\$ 38,050	\$ 60,850	
6 Person	\$ 34,590	\$ 40,850	\$ 65,350	
7 Person	\$ 39,010	\$ 43,650	\$ 69,850	
8 Person	\$ 43,430	\$ 45,500	\$ 74,350	

Total Number of Individuals in Household: \_\_\_\_\_

Based upon your TOTAL Household Income, Please check the appropriate category:

- Extremely Low                     
  Low                                     
  Moderate                                     
  Non Low-Moderate

Based on Applicant Demographics, Please check the appropriate category:

- White   
  American Indian or Alaska Native  
 Black/ African American                     
  Pacific Islander  
 Asian   
  Other/Multicultural

If the Applicant's is considered any of the following, Please check the appropriate categories:

- Disabled   
  Elderly (62 + years)  
 Hispanic   
  Female head of household

NAME / ADDRESS: \_\_\_\_\_

I certify all information provided to be true understanding that falsification of any item may result in program ineligibility and/or forfeiture of funds. I also understand that income may be verified at any point in time.

**1. Gender:**

Male  
 Female

**2. Ethnic Origin: (check one)**

White  Asian/Pacific Islander-of Other Origin  
 African American  Native American  
 Black-of Jamaican Origin  Bi-Racial: \_\_\_\_\_  
 Black-Unspecified Origin  Unknown/Other: \_\_\_\_\_  
 Black-of Other Origin  
 Hispanic-of Puerto Rican Origin  
 Hispanic-Unspecified 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  
 Asian/Pacific Islander of Indian/Pakistani Origin

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

Own Residence  Family Care  
 Rental Home/Apartment  Incarcerated (prison, jail, lock-up)  
 Home of Parent, Relative, or Friend  Foster Home (C&Y clients)  
 Rooming House, Hotel, SRO  Therapeutic Foster Home  
 Nursing/Health-Related Facility  RTF (C&Y Clients)  
 Institution  Transient/Homeless  
 Community Residence  Other  
 Adult Home (PPHA)  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  Some college  
 Less than high-school  2 year college degree  
 Some high school (8<sup>th</sup> grade or less)  4 year college degree  
 High-school/GED diploma  Graduate school  
 Vocational, technical, business school  Unknown

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

With Parent(s)  In Institution  
 With Siblings  In Residence Facility  
 With Spouse  No Permanent  
 With Children  With Other Relatives  Unknown

**8. Religion: (check one)**

Roman Catholic  Buddhist  Hindu  
 Protestant  Baptist  Christian Scientist  
 Methodist  Jewish  Unknown  
 Pentacostal  Islam  Other  
 Jehovah's Witness  
 Congregational Affiliation: \_\_\_\_\_  
(Please specify)

**9. Primary Language**

English  Braille  Spanish  Sign  
 Vietnamese  Other  Unknown

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

Tanif  Medicaid  SSI  Medicare  
 SSDI  Other  Unknown

**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.

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Participant Signature

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Age

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Date Signed

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Participant Name (Print)

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Witness (Therapist)

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Parent or Guardian Signature

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Date Signed

**Note: Please feel free to attach additional information.**

**If you would like to discuss this application or require further information, please call 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 with 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.

## 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 if, or when 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