Dear Referring Provider,

Thank you for your interest in referring your client to Compeer Rochester. Attached you will find our referral packet, Criteria for Acceptance, and a list of responsibilities you must agree to as the referral source. Please review each of these documents before submitting the referral to ensure your client is eligible for the program. You must complete the referral in its entirety, including the mandatory Consent for Release of Information. Please include supplemental documentation of your client’s psychosocial history as you see appropriate. Incomplete referrals will be returned.

It is difficult to predict how long it will take to find an appropriate volunteer for your client – matches are made based on several factors such as age, culture, personality traits, interests, level of client need, level of experience of the volunteer, and geographical location. Once a match is made, the service is expected to last at least one year, and is very rewarding for participants and volunteers alike. Some of our clients and volunteers have been matched for decades.

Compeer Rochester’s mission is to serve as a bridge to enhanced wellness and community integration for those with social and emotional barriers through the power of supportive friendships. We are proud to have served Monroe County for over 40 years, utilizing community volunteers in a person-centered approach to combat stigma and other challenges facing those with mental health conditions. We view our program as an adjunct to counseling and other types of mental health care; therefore, we look forward to partnering with you to meet the goals of your client.

Sincerely,

Sara Passamonte
President/Executive Director
Criteria for Acceptance Adult 1:1 Mentoring Program

Please complete this checklist prior to completing referral:

1. Does client reside in Monroe County? Yes No
2. Is client receiving ongoing mental health treatment in a facility licensed by the Office of Mental Health for a diagnosed mental health condition? Yes No
3. Is client interested in socializing and spending time out in the community with a volunteer? Yes No
4. Is client able to identify goals around overall wellness? Yes No
5. If client is using a wheelchair or has other mobility challenges, is he/she independent with transfers? Yes No

If all above questions are answered “Yes,” please proceed:

6. Has client ever been convicted of a sexual or violent offense? Yes No
7. Is client acutely suicidal? Yes No
8. Has client met criteria for a Substance Use Disorder within the last 12 months? Yes No
9. Has client been hospitalized in the past six months for a mental health concern? Yes No
10. Has client been assigned more than two previous Compeer Volunteers in the past? Yes No

If any of the above questions are answered “Yes,” please contact us prior to making referral. If all of the above questions are answered no, please proceed with referral and be sure to answer the questions below prior to submitting referral:

11. Is the referral completed in its entirety? Yes No
12. Is all information relating to client’s mental health history disclosed in the referral, including any history of behaviors that would be of concern to a volunteer’s safety (i.e. aggressive or violent behavior, chemical dependency, CPL status, stealing, dementia, severely impaired judgment, and recent hospitalizations)? Yes No
13. If available, is a current psychosocial assessment attached? Yes No

Information provided in the referral and supporting documents will be reviewed by Compeer Staff, and a decision will be made in the best interest of your client and our volunteers. All cases are reviewed on an individual basis. Compeer does not discriminate based on race, religion, or sexual orientation. If your client does not meet the above Criteria, he or she may still qualify for other services at Compeer Rochester. Contact us for more information about our fee-for-service programs.
RESPONSIBILITIES OF REFERRAL SOURCE/MENTAL HEALTH PROFESSIONAL

- You must have contact with potential volunteers to help determine the best match for individuals you refer. Potential volunteers will contact you directly, or Compeer staff will provide you with their contact information. Our Consent for Release of Information allows this contact until Compeer Rochester services end.
- You must be available by phone to Compeer staff and volunteers for issues of concern throughout the match.
- You may be asked to facilitate meetings and/or other forms of communication between clients you refer, volunteers, and/or Compeer staff before and during the match.
- You must notify Compeer of any changes in your client’s mental health, agency/mental health provider, or contact information.
- You must let us know if you close with clients you have referred as soon as possible. This applies to clients waiting for a volunteer and clients who are matched. We will not present an individual to potential volunteers unless he or she has a mental health professional or some form of counseling. If you close out a client while he or she is still matched, Compeer staff will determine eligibility to continue in the program.
- If you make a referral but do not intend to be the primary contact for us, you must submit the Consent of Release of Information for the alternate contact or agency along with the referral. You must verify the primary contact person is fully aware of and supportive of the referral, has a copy of this document, and can agree to the responsibilities listed above.
- If you know that your client is (HARP) eligible and or has a Health Home Care Manager (HHCM), you must disclose this information as requested in the accompanying referral, as Compeer may also be able to provide your client with Home and Community Based Services (HCBS), if they are eligible and elect to participate in such.

I have read, understand, and agree to the above responsibilities as the referring mental health professional:

______________________________  __________________________
Signature                                      Date

RESPONSIBILITIES OF COMPEER PROGRAM

- We will recruit, interview, screen, and provide training to volunteers before they are matched and give ongoing support and training during the match.
- We will monitor the volunteer and client relationship via phone/e-mail and monthly update forms, and will advise you of any concerns that may arise. We will mail, fax, or email you a copy of the volunteer’s monthly update form.
- We will get to know clients via Self-Reports, periodic Compeer-sponsored events, and checking in at least once every three months by phone. We may remove an individual from our services if contact is not returned by him or her, or you as the provider.
- We will offer advocacy and other Family Support Services by our Family Mentor to clients who are parents or caretakers of children who are also in mental health treatment.

~PLEASE ATTACH THIS SIGNED DOCUMENT TO ANY REFERRAL YOU SUBMIT~
MENTAL HEALTH PROFESSIONAL’S REFERRAL FORM - ADULT SERVICES

259 Monroe Avenue
Rochester, NY 14607-3632
Office: 585-546-8280
TTY: 585-546-7959
Fax: 585-325-2558
Website www.compeerrochester.org

Compeer Office Use Only:
Date Received: _______ by _______
Date Logged In: _______ by _______
Date Approved: _______ by _______
Referral Denied: _______ by _______

CLIENT ID __________

PROGRAM DESIRED (CHECK ALL THAT APPLY)
- 1:1 Mentoring Program (Volunteer-based, long-term)
- Supportive Partners for Recovery (Fee-for-service, short-term)
- CompeerCorps (Veterans only, group activities)
- Compeer Calling (1:1 supportive weekly phone contact)
- E-Buddies (1:1 supportive weekly e-mail contact)

REFERRAL DATE:

CLIENT INFORMATION

Client Name: Date of Birth: _____/_____/_____
Current Address: City: State: Zip:
Phone: E-mail address:

LIVING SITUATION
Lives with (self, spouse, parents, foster parents, relatives, friends, group home, in-patient, etc.)

Names, relationship to client, and birth dates of those in same home (group home or in-patient need not complete)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Birth date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Relationship:</td>
<td>Birth date:</td>
</tr>
<tr>
<td>Name:</td>
<td>Relationship:</td>
<td>Birth date:</td>
</tr>
</tbody>
</table>

EMERGENCY CONTACT

Name: Relationship to Client:
Phone (Day): Address:
Phone (Evening): City: Zip:

GOALS FOR COMPPEER RELATIONSHIP/WELLNESS

Prevention:

Emotional & Social:

Physical Activity/Nutrition:

PSYCHOSOCIAL INFORMATION
MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM - ADULT SERVICES

Does the client have access to transportation? □ Yes □ No
What type? □ Car □ Bus □ Other
Are there any special needs for transportation? If yes, please explain (i.e. wheelchair access, etc.):

Current involvement in programs (e.g. Day treatment, work, volunteering, and community recreation) - please list:

INTERESTS/HOBBIES/ACTIVITIES

□ Arts and Crafts: □ Sports: □ Movies:
□ Cooking: □ Outdoor Activities: □ Drama:
□ Sewing: □ Church/Temple: □ Volunteering:
□ Reading: □ Fitness Activities: □ Music:
□ Animals: □ Dining Out: □ Shopping:
Describe client's strengths and positive attributes:

Are groups difficult for your client? □ Yes □ No

How does your client handle frustration?

DSM DIAGNOSIS - PROVIDE NAME AND CODE

Primary: Environmental Stressors:

Secondary:

Medical Conditions: SPMI? □ Yes □ No

Symptomatic Behaviors (What does the volunteer need to know?):

PLEASE ATTACH PSYCHOSOCIAL REPORT, WHODAS AND/OR APPLICABLE ASSESSMENTS

Does client have any other medical conditions? □ Yes □ No
If yes, please describe:

Does client have any physical limitations? □ Yes □ No If yes, please describe

Does client take medication(s)? □ Yes □ No
MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM- ADULT SERVICES

CRIMINAL/LEGAL HISTORY

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does client have a history of illicit drug use?</td>
<td></td>
<td></td>
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<tr>
<td>If yes, please describe and state if and how long the client has been sober:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does client have a history of physically aggressive behavior?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, please describe and provide documentation, dates and a detailed account of the history:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has client ever been convicted of a felony or for any criminal activity?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, please describe and provide documentation, dates and a detailed account of the history:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MENTORING PREFERENCES: WHAT IS IMPORTANT TO YOUR CLIENT?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it important that the volunteer be a specific age, gender, religion, and ethnic background or have a specific quality?</td>
<td></td>
<td></td>
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<tr>
<td>If yes, please specify:</td>
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<td></td>
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<tr>
<td>What would not be a good match?</td>
<td></td>
<td></td>
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<tr>
<td>Does client smoke?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does it matter to client if volunteer smokes?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REFERRING INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referring Provider</td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Preferred Method of Contact</td>
<td></td>
</tr>
<tr>
<td>E-mail</td>
<td></td>
</tr>
<tr>
<td>Mail</td>
<td></td>
</tr>
<tr>
<td>Relationship/role with client</td>
<td></td>
</tr>
<tr>
<td>Type of treatment</td>
<td></td>
</tr>
<tr>
<td>Primary contact for Compeer Program?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If NO, please list information for primary contact

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Provider</td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
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<tr>
<td>Phone</td>
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<td>Relationship/role with client</td>
<td></td>
</tr>
<tr>
<td>Type of treatment</td>
<td></td>
</tr>
</tbody>
</table>

1. Is client HARP (Health and Recovery Plan)- eligible? | Yes | No | Unknown |
2. Does client have a Health Home Care Manager (HHCM)? | Yes | No | Unknown |

If YES to question 2, complete the following:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Home Care Manager Name</td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Required Email</td>
<td></td>
</tr>
</tbody>
</table>
1. Gender:
   - Male
   - Female
   - Transgender Male to Female
   - Transgender Female to Male
   - Other
   - Unknown

2. Race/Ethnicity:
   - White
   - Black / African American / Afro-Caribbean
   - Asian
   - American Indian / Alaska Native
   - Native Hawaiian / Pacific Islander
   - Multi-racial
   - Other
   - Unknown

2a. Hispanic/Latino Indicator
   - Not Hispanic/Latino
   - Mexican
   - Puerto Rican
   - Cuban
   - Dominican
   - Ecuadorian
   - Origin Not Specified
   - Unknown

3. Marital Status:
   - Never Married
   - Married
   - Widowed
   - Separated
   - Divorced/Annulled
   - Unknown

4. Education: (check last grade completed)
   - None
   - Less than high-school
   - Some high school (8th grade or less)
   - High-school/ GED diploma
   - Vocational / Technical School
   - Some college
   - 2 year college degree
   - 4 year college degree
   - Graduate school
   - Unknown

5. Primary Language:
   - English
   - Spanish
   - American Sign Language
   - Other

6. Religion:
   - Catholic
   - Baptist
   - Protestant
   - Jewish
   - Buddhist
   - Islam
   - Other
   - Unknown

7. Military Status – Client’s Parent/Legal Guardian
   - Yes, active duty (includes Reserves or National Guard)
   - Yes, in past (Veteran)
   - Yes, current active status unknown
   - No, training for Reserves or National Guard Duty
   - No, never served in military
   - Unknown

8. Criminal Justice or Juvenile Justice Status:
   - None
   - Criminal Procedure Law (CPL 330.20)
   - Article 10 – Sex Offender Management & Treatment
   - NYS Dept. of Corrections Prisoner
   - County/ City Jail, Court Detention or Police Lockup Prisoner
   - Parolee (Adults)
   - Probationer (Adults)
   - PINS (Persons in Need of Supervision)
   - Adjudicated Juvenile Delinquent or Offender
   - Alternative to Incarceration or Mental Health Court
   - Other
   - Unknown

9. Living Situation: (check one)
   - Private Residence (owned)
   - Rental Home/Apartment
   - Home of relative or friend
   - Rooming House, Hotel, SRO (non-MH)
   - Nursing/Health-Related Facility
   - Institution (ex. RPC)
   - Community Residence
   - Adult Home (PPHA)
   - Kinship/Family Care
   - Foster Home
   - Residential Treatment Facility
   - SRO (mental health)
   - Supported Housing/Apartment
   - Transient/Homeless
   - Other
   - Unknown

10. Additional Disabilities: Please specify
    - None
    - Developmental:
    - Intellectual:
    - Alcohol:
    - Drugs:
    - Mixed Substance:
    - Blind:
    - Deaf/HH:
    - Ambulation Impairment:
    - Other:
    - Unknown

11. 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
12. Health Insurance Coverage:
   - Medicaid
   - Managed Care Plan
   - Medicare
   - Private/Commercial/3rd Party Insurance
   - Child Health Plus
   - Family Health Plus
   - Other: __________________________
   - None

13. Employment Status
   - Full Time Employment Where: __________________________
   - Part Time Employment Where: __________________________
   - Sporadic or casual employment for pay
   - Volunteer or Intern
   - Not in Labor Force: looking for work
   - Not in Labor Force: retired, homemaker, student/child
   - Not in Labor Force: disabled, psychiatric inpatient
   - Not in Labor Force: other __________________________

14. Income Source: (check largest single source)
   - None
   - Full-time Employment
   - Part-time Employment
   - Alimony or Child Support
   - Unemployment
   - Pension, Social Security
   - Support from Employed Spouse
   - Support from Employed Parent
   - SSI
   - SSDI
   - ADC, Home Relief or other Welfare
   - VA Benefits
   - Worker's Compensation
   - Other: __________________________
   - Unknown

15. Aggregate Household Income
   - Less than $13,200
   - $15,000 - $24,999
   - $25,000 - $44,999
   - $45,000 - $74,999
   - $75,000 and Up
   - Unknown
Waiver of Liability

Compeer Rochester's programming involves a variety of activities. The level of participation in mentoring, events, or programs are at all times voluntary. Compeer Rochester staff members are committed to the safety of every participant, using several levels of volunteer screening and background checks, as well as choosing appropriate activities in the community. However, participants may be at risk for injury or other harm. This waiver must be completed and signed prior to enrollment.

Please list any medications and/or medical conditions not already mentioned in referral:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Medical coverage information:

Physician's Name_________________________________ Office Phone ____-____-______

Office address: ____________________________________________

Preferred Hospital (optional): ____________________________

Insurance Company:_____________________________ Policy # (optional) ______________

WAIVER: I realize that I must have proper medical insurance, including coverage for hospitalization. I understand that participating organizations do not provide accident insurance coverage. I further understand that I am participating at my own risk and assume the risk of injury. I am aware that the activities in which I participate could involve certain personal risks. I, therefore, release all rights or claims for damages against Compeer Rochester, Inc., and all individuals assisting and conducting these activities for any injuries suffered by me in connection with this activity.

__________________________________________________________________________  _____________________________________________________________________
Client’s Signature                                           Date

__________________________________________________________________________
Client’s Name (print please)

__________________________________________________________________________
Witness’s Signature
Consent for Release of Information

I, ________________________________________, give permission to exchange educational and psychosocial diagnostic, assessment, and treatment information, as well as descriptive information about symptoms and behaviors regarding:

Client’s Name ___________________________ Date of birth: ________________

I hereby declare that I am the: ( ) Patient /Client  ( ) Legal Guardian

This information may be obtained from and released to:

Agency: ____________________________________________
Address: ____________________________________________

Phone #________________________ Fax # ___________________________

This information may be obtained from and released to:

Compeer Rochester, Inc. (Staff, Interns, and Volunteers)
259 Monroe Ave.
Rochester, NY 14607
Phone: 585-546-8280 Fax: 585-325-2558

Compeer Rochester must report to its funders to ensure continuation of services. In addition to agency staff, client names and service hours may be shared with licensed researchers and authorized funders in order to measure the impact of mentoring in our community. Compeer Rochester honors client privacy and will never share detailed information about a client’s mental health status or diagnoses with any parties not authorized by the client.

I authorize the ongoing release of this information for the purpose of finding a volunteer mentor, and also to support the volunteer throughout the duration of his or her match with me in the Compeer Program. This consent expires when Compeer services are discontinued. I understand that I have the right to revoke and or restrict this authorization at any time, provided that I submit a request in writing to the referring agency. Any revocation shall not apply to the extent that the referring agency has already taken action in reliance on this authorization.

Client Signature: _______________________________ Date: ___________________

Staff/Mental Health Professional Signature: ___________________________ Date: ___________________