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,

[Signature]

Sara Passamonte
President/Executive Director
CRITERIA FOR ACCEPTANCE - YOUTH 1:1 MENTORING PROGRAM

Please complete this checklist prior to completing referral:

1. Is client between the ages of 5 and 21?  Yes  No
2. Does client reside in Monroe County?  Yes  No
3. Is client experiencing a mental or behavioral health condition?  Yes  No
4. Is client interested in socializing and spending time out in the community with a volunteer?  Yes  No
5. Is client’s parent or guardian aware that referral is being made and supportive of referral?  Yes  No
6. If referral is being made by a school-based Mental Health Professional, is there an alternative contact available during school break aside from the parent or caretaker (ex: outside therapist), or is referral source available by e-mail?  Yes  No

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

7. Has client ever been convicted of a sexual or violent offense?  Yes  No
8. Is client acutely suicidal?  Yes  No
9. Is client diagnosed with a Substance Use Disorder?  Yes  No
10. Is client medically fragile?  Yes  No
11. Has client been hospitalized in the past six months for a mental health concern?  Yes  No
12. Is client active in Skillbuilding or any other mentoring programs?  Yes  No
13. 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:

14. Is the referral completed in its entirety?  Yes  No
15. 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 (ex. aggressive or violent behavior, chemical dependency, stealing, and recent hospitalizations)?  Yes  No
16. 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.
RESPONSIBILITIES OF REFERRAL SOURCE / MENTAL HEALTH PROFESSIONAL

- You must have contact with potential volunteers to help determine the best match for youth 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 and ongoing 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 youth you refer, their parents or guardians, volunteers, and/or Compeer staff before and during the match.
- You must notify Compeer of any changes in a youth’s mental health (including diagnosis and hospitalizations), agency/mental health provider, school, or contact information.
- **You must let us know if you close with youth you refer as soon as possible.** This applies to youth waiting for a volunteer and youth who are matched. We will not present a youth to potential volunteers unless he or she is receiving an appropriate level of mental health treatment. If you close out a youth while he or she is still matched, Compeer staff will determine eligibility of youth 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.**

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 youth 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 if it contains relevant information.
- We will get to know youth and their families via Parent Orientation, the Youth Self-Report, periodic Compeer-sponsored events, and checking in at least once every three months by phone. **We may remove a youth from our services if contact is not returned by the parent/caretaker or you as the provider.**
- We will offer advocacy and other Family Support Services by our Family Peer Mentor to parents and caretakers as soon as a youth is enrolled, as well as throughout a match.

~PLEASE ATTACH THIS SIGNED DOCUMENT TO ANY REFERRAL YOU SUBMIT~
YOUTH 1:1 MENTORING PROGRAM REFERRAL

REFERRAL DATE __/__/____

YOUTH CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth: <strong>/</strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
<tr>
<td></td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td>Zip:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Parent/Caretaker's Phone:</td>
</tr>
<tr>
<td></td>
<td>E-mail Address:</td>
</tr>
</tbody>
</table>

YOUTH'S HOUSEHOLD MEMBERS (group home/in-patient facility 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>
<tr>
<td>Name:</td>
<td>Relationship:</td>
<td>Birth date:</td>
</tr>
<tr>
<td>Name:</td>
<td>Relationship:</td>
<td>Birth date:</td>
</tr>
<tr>
<td>Legal Guardian's Name and Address (if different):</td>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td>Phone:</td>
<td></td>
</tr>
</tbody>
</table>

EMERGENCY CONTACT

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship to Youth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone (Day):</td>
<td>Phone (Evening):</td>
</tr>
</tbody>
</table>

SUPPLEMENTAL CONTACT INFORMATION (if not listed above)

<table>
<thead>
<tr>
<th>Parent/Caretaker's Name:</th>
<th>Parent/Caretaker's Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Zip:</td>
<td>City:</td>
</tr>
<tr>
<td>Work phone:</td>
<td>Home phone:</td>
</tr>
<tr>
<td>Occupation:</td>
<td>E-mail:</td>
</tr>
</tbody>
</table>

YOUTH'S INTERESTS/HOBBIES/ACTIVITIES (please specify if possible)

- Arts and Crafts:
- Sports:
- Movies:
- Dining Out:
- Outdoor Activities:
- Volunteering:
- Collecting:
- Cooking:
- Games:
- Reading:
- Fitness Activities:
- Music:
- Animals:
- Dancing:
- Shopping:

Please describe other interests not listed above, youth's strengths and positive attributes.
**DSM Diagnosis – Provide Name and Code**

<table>
<thead>
<tr>
<th>Primary:</th>
<th>Environmental Stressors:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary:</th>
<th>Seriously Emotionally Disturbed? □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(severe functional impairment or symptoms of psychosis, and multiple risk-factors)</td>
</tr>
</tbody>
</table>

**Please Attach Psychosocial Report, WHODAS and/or Applicable Assessments**

**Please Describe Youth's Interaction Skills in Each Setting**

<table>
<thead>
<tr>
<th>Group:</th>
<th>1:1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured:</td>
<td>Unstructured:</td>
</tr>
<tr>
<td>Ability to Adhere to Limits:</td>
<td>Ability to Tolerate Frustration:</td>
</tr>
</tbody>
</table>

- How does youth interact with those with authority (i.e. parent, physicians, mental health professionals)?
- How does youth interact with peers?
- How does youth interact with those of different ages?

**Please Provide Additional Information**

<table>
<thead>
<tr>
<th>What School Does the Child Attend?</th>
<th>Grade Level:</th>
<th>School ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Personality Traits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptomatic Behaviors:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Does youth have a history of physically aggressive behavior? □ Yes □ No Please describe:
- Has youth ever been charged with or convicted of a crime? □ Yes □ No If yes: What was the nature of the offense(s)? Location and Month/Year
- Does youth have any other medical conditions? □ Yes □ No Please describe:
- Does youth have any physical limitations? □ Yes □ No Please describe:
- Medication(s)/side effects a volunteer should be aware of:
- Does youth or youth's parent have a history of illicit drug use? □ Yes □ No Please describe:
- Are either parent(s) incarcerated? □ Yes □ No If yes, which facility?
Has there been a Child Protective Services case opened with this family in the last year?  
☑ Yes  ☐ No  
Please describe:

Are parent(s) / legal guardian supportive of youth’s referral to Compeer?  
☑ Yes  ☐ No  

Does the youth have access to transportation?  
☑ Yes  ☐ No  
Are there any special needs (wheelchair, etc)?  
☐ Yes  ☐ No  

Please list:

Does youth participate in other programs (after-school, faith-based, vocational training/part-time job/volunteer work, recreational)?  
☑ Yes  ☐ No  
Please list:

Please note: Youth currently receiving Skillbuilding services will not be matched until Skillbuilding has ended or is coming to a close

Youth availability to meet with Compeer Volunteer:  
☑ Daytime  ☐ Evenings  ☐ Weekdays  ☐ Sat  ☐ Sun

Is it important that the volunteer be a specific age, gender, religion, ethnic background, or have a specific quality?  
☑ Yes  ☐ No  
Please specify:

### GOALS FOR COMPEER RELATIONSHIP/WELLNESS

<table>
<thead>
<tr>
<th>Prevention:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional:</td>
</tr>
<tr>
<td>Social:</td>
</tr>
<tr>
<td>Physical Activity/Nutrition:</td>
</tr>
</tbody>
</table>

### REFERRAL SOURCE INFORMATION:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

Best time to call:  
Relationship/role with youth:  
Type of treatment (individual, family, group, medication):  

Frequency of contact with youth:  
Primary contact for Compeer Program?  
☑ Yes  ☐ No  
If no, complete box below

Primary Mental Health Professional Contact:  
Title:  
Agency:  
Address:  
City:  
State:  
Zip:  
Phone:  
Fax:  
Email:  

Best time to call:  
Relationship/role with youth:  
Type of treatment (individual, family, group, medication):  

Frequency of contact with youth:
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

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
   _ Unknown

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/Homless
   _ 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
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:

( ) Client              ( ) Parent              ( ) 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 or client's guardian.

By signing below, I understand and agree to the above content and authorize the ongoing release of information for the purpose of finding a volunteer mentor for myself or for my child, and also to support the volunteer throughout the duration of his or her match with me or my child 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: ____________
(if client is 18 or over)

Parent or Guardian Signature ______________________________ Date: ____________

Staff/Mental Health Professional’s Signature ________________ Date: ____________
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.

I, ____________________________, give permission for my child/youth, ____________________________,

Parent’s Name Youth’s Name

to participate in all Compeer activities unless otherwise stated below:

Please list any medications not already mentioned in referral:

Physician’s Name_________________________ Office Phone _____ - _____ - _______

Office address: ________________________________

Preferred Hospital: _____________________________

Insurance Company:_________________________ Policy # __________________

WAIVER: I realize that I must provide proper medical insurance, including hospitalization. I understand that participating organizations do not provide accident insurance coverage. I further understand that my child/youth is participating at his/her own risk and assume the risk of injury. I am aware that the activities in which my child/youth plans to 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 my child/youth in connection with this activity.

Parent/Legal Guardian_________________________ Date __________________
PHOTO AND VIDEO RELEASE

I, THE UNDERSIGNED, HEREBY GRANT TO COMPEER ROCHESTER, INC. PERMISSION TO TAKE PICTURES AND/OR TAPE THE UNDERSIGNED. I ALSO GRANT TO COMPEER ROCHESTER, INC. PERMISSION TO USE THE FINISHED PICTURES AND/OR TAPE FOR ANY LAWFUL PURPOSE. FURTHER, I GRANT TO COMPEER ROCHESTER, INC. ALL RIGHTS, TITLE AND INTEREST TO THE FINISHED PRODUCT, MASTERS, REPRODUCTIONS AND COPIES OF THE ORIGINAL PICTURES AND/OR TAPES, INCLUDING THE RIGHT TO GIVE, SELL AND TRANSFER THE PICTURES, TAPE OR REPRODUCTIONS THEREOF. I ACKNOWLEDGE THAT RETRACTION OF THIS PERMISSION MUST BE COMPLETED IN WRITING TO COMPEER ROCHESTER, INC.

Child's Name

(Please Print)

PARENT OR GUARDIAN (Please Print)

SIGNATURE: ____________________________

ADDRESS: ________________________________

TELEPHONE: (_____) __________________________

Please describe any limitations to this consent:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Circle one:* Enrolled Client Matched Client Matched Volunteer Board Member Family Member Other:
