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- 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: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City:</td>
</tr>
<tr>
<td>Phone</td>
<td>Parent/Caretaker’s Phone:</td>
</tr>
<tr>
<td>E-mail Address:</td>
<td></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>
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<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>

<table>
<thead>
<tr>
<th>Legal Guardian’s Name and Address (if different):</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone:</td>
<td></td>
<td></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>State:</td>
<td>Zip:</td>
</tr>
<tr>
<td>Home phone:</td>
<td>Work phone:</td>
</tr>
<tr>
<td>Occupation:</td>
<td>Occupation:</td>
</tr>
<tr>
<td>E-mail:</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>Secondary:</td>
<td></td>
</tr>
<tr>
<td>Medical Conditions:</td>
<td>Seriously Emotionally Disturbed? ☐Yes ☐No</td>
</tr>
</tbody>
</table>

(severe functional impairment or symptoms of psychosis, and multiple risk-factors)

**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>
</table>

General Personality Traits:

Symptomatic Behaviors:

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**

**Prevention:**

**Emotional:**

**Social:**

**Physical Activity/Nutrition:**

**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>

<table>
<thead>
<tr>
<th>Best time to call:</th>
<th>Relationship/role with youth:</th>
<th>Type of treatment (individual, family, group, medication):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Frequency of contact with youth:</th>
<th>Primary contact for Compeer Program?</th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If no, complete box below:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Primary Mental Health Professional Contact:**

| Agency: | |
|---------| |
| Address: | City: | State: | Zip: |
| Phone: | Fax: | Email: |

<table>
<thead>
<tr>
<th>Best time to call:</th>
<th>Relationship/role with youth:</th>
<th>Type of treatment (individual, family, group, medication):</th>
</tr>
</thead>
</table>

| 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

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/SED 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/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
   ___ 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:
Authorization for Access to Patient Information
Through a Health Information Exchange Organization

PROVIDER: Compeer Rochester, Inc.

Patient Name | Date of Birth | Patient Identification Number
---|---|---

Patient Address

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people’s health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO’s website at [www.RochesterRHIO.org](http://www.RochesterRHIO.org).

My Information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

<table>
<thead>
<tr>
<th>My Consent Choice</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I give consent for above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).</td>
<td></td>
</tr>
<tr>
<td>I deny consent for above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, even in a medical emergency.</td>
<td></td>
</tr>
</tbody>
</table>

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO’s website at [www.RochesterRHIO.org](http://www.RochesterRHIO.org) or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient’s Legal Representative | Date
---|---

Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable)
---|---

DOH-form number pending (3/15)