

Dear Provider,

Thank you for your interest in referring your client to Compeer Rochester. Please review the enclosed referral and accompanying documents to ensure your client is eligible for the program, and complete them in entirety, including the Consent for Release of Information for any providers listed in the referral. Incomplete referrals will be returned. Please include supplemental documentation of your client’s psychosocial history if available.

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—some of our participants have been matched for decades!

We are proud to have served Monroe County for nearly 50 years, utilizing community volunteers and staff in a person-centered approach to combat stigma and other challenges facing those with mental health challenges. We view our program as an adjunct to counseling and other mental health. We look forward to partnering with you and your client to meet their goals and expectations.

Sincerely,



Sara Passamonte

President/Executive Director

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**Providing Mental Wellness in our Community**

**Since 1973**

**259 Monroe Avenue**

**Rochester, NY 14607**

**(585) 546-8280**

**www.compeerrochester.org**

Sara Passamonte

President/Executive Director

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**Section A: 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

1. Is client interested in socializing and spending time out in the community with a volunteer? Yes No
2. Is client able to identify goals around overall wellness? Yes No
3. Does client have mobility challenges? Yes No
   1. If “yes”, is client independent with transfers? Yes No
   2. If “no”, please contact Compeer before submitting referral.

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

1. Has client ever been convicted of a sexual or violent offense? Yes No
2. Is client acutely suicidal? Yes No
3. Has client met criteria for a Substance Use Disorder within the last 12 months? Yes No
4. Has client been hospitalized in the past six months for a mental health concern? Yes No
5. 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:**

1. Is the referral completed in its entirety? Yes No
2. **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**

1. If available, is a current psychosocial assessment attached? Yes No

*Compeer does not discriminate based on race, religion, or sexual orientation. If your client does not meet the above Criteria, they may still qualify for other services at Compeer Rochester. Contact us for more information about our fee-for-service programs.*

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SECTION B: RESPONSIBILITIES OF REFERRAL SOURCE/MENTAL HEALTH PROFESSIONAL

* Potential volunteers will contact you directly or be connected to you by Compeer Staff to determine the best match for your client. The written consent form allows for this contact until Compeer 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 us of any changes in your client’s mental health, mental health provider, and contact information.
* You must let us know if you discharge or transfer the client 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 who are not actively in treatment. If you discharge your client while they are matched, Compeer staff will determine eligibility to continue services.
* 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. 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 they may be eligible for other services.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 monthly and will promptly advise you of any concerns. We will mail, fax, or email you a copy of the volunteer’s monthly update form quarterly or more frequent as needed.
* 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.**
* We will offer Family Support Services 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~**

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259 Monroe Avenue **Compeer Office Use Only:**

Rochester, NY 14607-3632 Date Received: by

Office: 585-546-8280 Date Logged In: by

TTY: 585-546-7959 Date Approved: \_\_\_\_\_\_\_\_\_ by \_\_\_\_\_

Fax: 585-325-2558 Referral Denied: \_\_\_\_\_\_\_\_by \_\_\_\_\_

#### Website [www.compeerrochester.org](http://www.compeerrochester.org)

**CLIENT ID**

#### PROGRAM DESIRED (CHECK ALL THAT APPLY)

#### Adult 1:1 Program (In-person services)

#### Compeer Calling/ E-Buddies (Weekly phone or email contact)

|  |
| --- |
| REFERRAL DATE: |
|  |

**SECTION 1: CLIENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name: | Date of Birth:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | |
| Preferred Name: | Preferred Pronouns: | | |
| Current Address: | City: | State: | Zip: |
| Phone: | E-mail address: | | |

# 

**SECTION 2: GOALS FOR COMPEER RELATIONSHIP/WELLNESS**

|  |
| --- |
| Personal Goals: |
| Emotional & Social: |
| Physical Activity/Nutrition: |

**SECTION 3: DIAGNOSTIC INFORMATION (PLEASE PROVIDE DSM NAME AND CODE)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Primary: | Environmental Stressors: | | Secondary: | | Symptomatic Behaviors: | SPMI? Yes No | | *PLEASE ATTACH PSYCHOSOCIAL REPORT OR APPLICABLE ASSESSMENTS IF AVAILABLE* | | |
| Does client have any other physical limitations or medical conditions? Yes\* No  \*If yes, please describe: |
| Is client able to walk, stand up independently? Yes No\* \*If no, please describe mobility level with assistance or ambulatory assistive devices (i.e., wheelchair, walker, etc.) |
| Does client take prescription medication(s)? Yes No |

#### SECTION 4: ADDITIONAL HISTORY

|  |
| --- |
| Does client currently or have a history of substance use? Yes\* No  \*If yes, please describe and state if and how long the client has been sober: |
| Does client have a history of physically aggressive behavior? Yes\* No  \*If yes, please describe and provide date of last occurrence: |
| Has client displayed behaviors that may put a volunteer at risk of any kind? Yes\* No \*If yes, please describe and provide documentation, dates and a detailed account of the history: |

**SECTION 5: PROVIDER INFORMATION**

**\*Please complete this section in its entirety and obtain consent for release of information prior to submitting referral.**

**\*\*Client must be in ongoing treatment with a mental health provider at time of referral and at time of match.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Referring Provider | | | | | | Title: | |
| Agency: | | | | | | | |
| Address: | | | | | City: | | Zip: |
| Phone: | Fax: | | Email (required): | | | | |
| Preferred Method of Contact: E-mail Phone | Relationship/role with client: | | | Frequency of Contact: | | | |
| Expected length of services: | | Type of treatment (individual, family, care management, etc.): | | | | | |
| Primary contact for Compeer Program? Yes No*-please list information for primary contact below* | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Primary Provider: | | | | | | Title: | |
| Agency: | | | | | | | |
| Address: | | | | | City: | | Zip: |
| Phone: | Fax: | | Email (required): | | | | |
| Preferred Method of Contact: E-mail  Phone | Relationship/role with client: | | | Frequency of Contact: | | | |
| Expected length of services: | | Type of treatment: | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medical Physician: | | | | Title: | |
| Office Address: | | | City: | | Zip: |
| Office Phone: | Fax: | Insurance Company: | | | |
| Preferred Hospital: | Insurance Policy Number (optional): | | | | |

1. Is client **HARP (Health and Recovery Plan)-** eligible?   Yes      No     Unknown

2. Does client have a Health Home Care Manager?   Yes      No     Unknown

**If YES to question 2, complete the following:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Health Home Care Manager Name: | | | | Title: | |
| Agency: | | | | | |
| Address: | | | City: | | Zip: |
| Phone: | Fax: | Required Email: | | | |

|  |  |
| --- | --- |
| ***SECTION 6: Please check all that apply:***  ***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\_\_\_\_\_\_\_\_\_\_\_\_\_\_*    **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* | **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 |

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**SECTION 7: Consent for Release of Information**

7a: I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to exchange educational and psychosocial diagnostic, assessment, and treatment information, as well as descriptive information about symptoms and behaviors regarding:

7b: Client’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**7c: 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.

**7d: Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

Staff/Mental Health Professional Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: