Compeer is a non-profit organization serving Chautauqua County that matches volunteers with a person referred to the program by a mental health professional.

Adult/Youth Referral Packet

All information requested is essential to facilitate the matching process and is, of course, **confidential**. Pertinent information, both psychiatric and medical, is necessary for funding compliance.

Positively reflecting the applicant's personality (ex. appreciative, likeable, easy to talk to, etc), as well as demonstrating a need and desire for a volunteer, enhances an applicant's chance of being matched.

Also, in considering the requirements for all of our funding sources, please complete the referral to the best of your ability and as accurately as possible.

Please return application to:
Compeer Chautauqua

South County
1351 North Main Street
Jamestown, NY 14701
(716) 487-2956
Fax (716) 484-3989

North County
715 Central Avenue
Dunkirk, NY 14048
(716) 366-3161
Fax (716) 366-7840

Toll free 1-800-887-7337
www.chqcompeer.com

Sponsored by Southern Tier Environments for Living, Inc.

TY ☐ DB ☐

Compeer Chautauqua Adult/Youth Referral Form

Referral Date: _____ ☐ **Adult Referral** ☐ **Youth Referral**

CLIENT INFORMATION

Client Name:	Date of Birth:	Phone:	Email:
Current Address:	City:	State:	Zip:
Physical Description:	Race:	Religion	Smoker: ☐ Yes ☐ No

Living Situation:	☐ Self ☐ Spouse ☐ Parents ☐ Relatives ☐ Friends ☐ Group Home
Client Contact with Family	☐ Frequently ☐ Occasionally ☐ Never
If contact, family name(s)	Relationship:
Address:	Phone:
If children, list names and ages:	

PSYCHOSOCIAL INFORMATION

Does the client have access to transportation? ☐ Yes ☐ No

What type? ☐ Car ☐ Bus ☐ Other _____

Are there any special needs for transportation? ☐ Yes ☐ No

If yes, please explain (i.e. wheelchair access, etc.) _____

Please list current involvement in programs (i.e. day treatment, work volunteering, community recreation):

Please check interests, hobbies and activities:

☐ Arts	☐ Crafts	☐ Sewing	☐ Reading	☐ Collecting
☐ Shopping	☐ Dining Out	☐ Gardening	☐ Outdoor activities	☐ Fitness Activities
☐ Dancing	☐ Cooking	☐ Volunteering	☐ Movies	☐ Dramas
☐ Sports	☐ Music	☐ Games	☐ Animals	☐ Church/Temple

☐ Other (list):

Describe strengths and positive attributes:

Describe general personality/social functioning (i.e. engaging, defensive, anxious, verbal, quiet etc.):

Does the client have any medical conditions? ☐ Yes ☐ No If yes, please describe:

Does the client have any physical limitations? ☐ Yes ☐ No If yes, please describe:

DSM IV DIAGNOSIS

Axis I (Primary):	Axis I (Secondary):
Axis II:	Axis III:
Seriously & Persistently Mentally Ill Adult ☐ Yes ☐ No	
Symptomatic Behaviors (What does the volunteer need to know?):	

COMPEER SERVICES

Please check the type of service the client may benefit from Compeer. (Check all that apply):

- ☐ 1:1 Individual Match
- ☐ Compeer Calling – supportive phone contact while on waiting list
- ☐ E-buddies – supportive email contact
- ☐ Group Events / Friends for a Day or Skill Building events while on waiting list

GOALS FOR COMPEER RELATIONSHIP/RECOVERY PLAN

1.
2.
3.

COMMENTS

Is it important that the volunteer/mentor be a specific age, religion, ethnic background or have a specific quality?

☐ Yes ☐ No Age: _____ Race _____ Religion_____ Other _____

Client availability: ☐ Daytime ☐ Evening ☐ Weekdays ☐ Weekends

Does it matter to client if volunteer smokes? ☐ Yes ☐ No

REFERRING INFORMATION

Referral Submitted By:		Title:	
Agency:			
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Best time to call:	Relationship/Role with client:		
Frequency of contact with client:	Primary contact for Compeer Program? ☐ Yes ☐ No		

IF NO, PLEASE LIST INFORMATION FOR PRIMARY CONTACT

Name of Primary Mental Health Professional:		Title:	
Agency:			
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Best time to call:	Relationship/Role with client:		
Frequency of contact with client:	Primary contact for Compeer Program? ☐ Yes ☐ No		

Please return application to:

1351 North Main Street • Jamestown, NY 14701 • (716) 487-2956 • Fax (716) 484-3989 or
715 Central Avenue • Dunkirk, NY 14048 • (716) 366-3161 • Fax (716) 366-7840

AUTHORIZATION FOR RELEASE OF INFORMATION

Consumer's Name (Last, First, MI) _____

Sex: _____ Date of Birth: _____

Facility Name: COMPEER CHAUTAUQUA

This authorization must be completed by the Consumer or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to by Used/Disclosed:

Information for referral to Compeer and information about and adult or child's identity, diagnosis, treatment, prognosis, and may contain information about psychiatric and/or substance abuse diagnosis.

Purpose or Need for Information

1. This information is being requested:

☒ by the individual or his/her personal representative; or

☐ other (please describe) _____

2. The purpose of the disclosure is (please describe):

To ensure support and services deemed therapeutically essential by Compeer staff, volunteer, mentor, and named support personnel.

From: Name, Address, & Title of Person/ Organization/Facility/Program Disclosing Information	**To:** Name, Address, & Title of Person/Organization/Facility/Program to Which this Disclosure is to be Made *NOTE: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*
	Compeer Chautauqua/ **STEL, Inc.** **1351 North Main Street** **Jamestown, NY 14701**

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:
   1. Only this information may be used and/or disclosed as a result of this authorization.
   2. This information is confidential and cannot legally be disclosed without my permission.
   3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
   4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (*insert name of facility/program*) **Compeer Chautauqua**
   5. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

B-1 **One-Time Use/Disclosure:** I hereby permit the one-time use or disclosure of the information described above to the person/ organization/facility/program identified above.

My authorization will expire:

☐ When acted upon:

☐ 90 Days from this date;

☐ Other:

Continue on Next Page →

AUTHORIZATION FOR RELEASE OF INFORMATION

State of New York
OFFICE OF MENTAL HEALTH

Facility /Agency Name	Consumer's Name (Last, First, M.I.)	"C"/Id. No.

B-2 **Periodic Use/Disclosure:** I hereby permit the one-time use or disclosure of the information described above to the person/ organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

☐ When I am no longer receiving services from *(insert name of facility/program);*

☐ One year from this date;

☐ Other:

C. **Consumer Signature:** I certify that I authorize the use of my health information as set forth in this document.

Signature of Consumer or Personal Representative _____ Date _____

Consumer's Name (printed) _____

Personal Representative's Name (printed) _____

Description of Personal Representative's Authority to act for the Consumer (required if Personal Representative signs Authorization) _____

D. **Witness Statement:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the Consumer and/or the Consumer's personal representative.

WITNESSED BY: _____
Staff person's name and title

Authorization Provided To: _____

Date: _____

To be Completed by Facility:

_____
Signature of Staff Person Using/Disclosing Information

_____
Title

_____
Date Released

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

_____
_____
_____

I hereby refuse to authorize to use/disclosure indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

_____
_____
_____

Signature of Consumer or Personal Representative _____ Date _____

Consumer's Name (printed) _____

Personal Representative's Name (printed) _____

Description of Personal Representative's Authority to act for the Consumer *(required if Personal Representative signs Revocation of Authorization)* _____

INFORMATION SHEET FOR CONSUMERS
Rights & Responsibilities
(Applicant's Copy)

- I have the right to have my privacy and confidentiallity protected and respected and to be treated with dignity by the Compeer volunteer and staff.
- I have the responsibility to treat the volunteer with respect and in a courteous manner.
- I understand that the volunteer is a friend, role model and if needed an advocate. The volunteer is not a health professional.
- I understand that a friendship takes time to develop and sometimes people are not compatible; however, I will give the friendship at least a few trial visits before terminating.
- I understand that activities undertaken should be affordable and mutually agreed upon by the volunteer and myself. I will pay for myself during outings.
- I will not attend any activities with the volunteer that include drugs or dangerous situtations. I will not engage in irresponsible use of alcohol.
- I understand that activities should take place in public places until both the volunteer and I feel comfortable.
- I understand that the volunteer has agreed to volunteer for a minimum of four hours a month for at least one year. This does not necessarily mean the friendship will end after twelve months, but it may.
- I understand that the volunteer is required to submit a monthly report to Copeer and my health professional, which will describe the amount and type of contact we have had. If I prefer, we can complete this report form together.
- I understand that if I make any threats to harm myself or somebody else that the volunteer has a duty of care to contact my health professional, Compeer staff or other appropriate persons to ensure my safety. I also understand that if my volunteer has any concerns, that they have the duty to report this to Compeer.
- I have the responsibility to complete a Compeer Annual Survey, and inform Compeer if my address or phone number changes.
- I will not attend any overnight or out-of-town trips with my Compeer volunteer unless it has been cleared with my health professional and the Compeer Coordinator **in advance**.
- I understand that the Compeer friendship is made up of myself, the volunteer, the Compeer staff and my health professional.