



WELCOME TO COMPEER OF GREATER BUFFALO!

Compeer's mission is to use the power of volunteer friends and mentors to improve the lives of children and adults striving for good mental health.

ADULT & SENIOR REFERRAL PACKET

1. A Mental Health Professional and the individual who is in need of services should complete this application.
2. Please read and keep the Application Guidelines. *(For the mental health professional)*
3. Please fill out the **Eligibility Criteria Form. (Return this to Compeer)**
4. Please fill out the **five-page Application. (Return this to Compeer)**
5. Please review the Information Sheet for Consumers. *(For the Applicant)*
6. Please sign and have witnessed the **Release of Information form. (Return to Compeer)**
7. **Return the forms indicated to Compeer of Greater Buffalo.**

Please make a copy of the completed, signed application for your records.

Return the required forms to:

Compeer of Greater Buffalo
135 Delaware Ave. Suite 210
Buffalo, NY 14202

Or you can fax it to: (716) 883-3395

Feel free to call us at (716) 883-3331 if you have any questions. Once we receive and accept the completed application, you will receive a welcome to Compeer letter.

Thank you for your interest in the Compeer Program.

PLEASE RETURN PAGES 3-9 TO COMPEER.

Revised KBP 9-9-10

APPLICATION GUIDELINES

(For the Applicant and the Mental Health Professional)

Compeer volunteers come from all over Erie County. They are screened, trained and supported to offer regular individual social activities with approved applicants for about an hour a week for a twelve-month period. The friendship can be a valuable adjunct to your therapeutic interaction with consumers who could benefit from a social friendship. All information is confidential. Only pages 5-8 are shared with a potential volunteer during the matching process.

PLEASE NOTE:

- All information requested is essential to facilitate the matching process and is, of course, confidential. You are welcome to make copies of this blank application packet for future use.
- 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.
- Pertinent information, both psychiatric and medical, should always be disclosed – either on the referral form or in conversation with the Compeer Coordinator.
- A delay may occur in matching the applicant due to the high demand for Compeer volunteers. Please help us by only applying for those consumers who are most suitable and most in need. Please ensure that the applicant understands that there may be a long waiting period.
- Mental Health Professionals play an important role in choosing a volunteer and supporting the Compeer relationship as it develops. You are the primary contact for issues regarding your client. In your role of monitoring the friendship, **you (the mental health professional):**
 - Will ask your client about their Compeer activities during your regular consultations
 - Are available for the volunteer to discuss any concerns regarding your client
 - Receive copies of the volunteer's monthly report.
 - Will be contacted by Compeer staff if concerns arise
 - Let Compeer know if your client ends services with you or if there is a change in any information.
- As the primary support system for the volunteer, **Compeer:**
 - Contacts the volunteer after the first meeting and regularly throughout the friendship
 - Provides phone access & support during office hours
 - Requires written monthly reports from volunteers
 - Conducts ongoing training and Peer Support meetings on a regular basis
 - Provides one-to-one supervision as necessary

Please ensure that you have the time to fulfill these responsibilities before making the application

PLEASE KEEP THIS FORM FOR YOUR RECORDS



COMPEER REFERRAL FORM
Compeer of Greater Buffalo
135 Delaware Avenue, Suite 210
Buffalo, NY 14202
Phone: (716) 883-3331 Fax: (716) 883-3395

ELIGIBILITY CRITERIA FOR THE COMPEER PROGRAM

Part A

(Circle One)

1.	The applicant's primary diagnosis is an identified mental health disorder. <u>REQUIRED</u>	YES / NO
2.	The applicant lives in Erie County, NY. <u>REQUIRED</u>	YES / NO
3.	The Mental Health Professional completing this referral form agrees to support the friendship by talking with the applicant, volunteer and Compeer staff prior to, and if necessary, during the 12 month friendship as outlined in the Application & attached Matching Procedures.	YES / NO
4.	The applicant is in the recovery phase of their illness and is not acutely suicidal.	YES / NO
5.	The applicant is in the recovery phase of their illness and is not physically or verbally aggressive.	YES / NO
6.	The applicant is in the recovery phase of their illness and does not have thoughts to harm self or others.	YES / NO
7.	The applicant <u>wants</u> but lacks friends , and has limited social supports.	YES / NO
8.	The applicant is asking for more social contact and is willing to participate in the Compeer program.	YES / NO
9.	The applicant understands and respects the limits of the Compeer relationship as a two-way friendship as outlined in Consumer's Rights and Responsibilities	YES / NO
10.	The applicant has some insight into his/her illness.	YES / NO
11.	The applicant is 18 years of age or over. <i>(If under 18, please call the Compeer office for a child referral form).</i>	YES / NO

If you answered YES to all criteria above, please proceed with the application

If you answered NO to one or more of the criteria above, please contact Compeer **prior** to completing this form
 Criteria #1 and #3 above may be waived for seniors over the age of 60. Please contact Compeer.

Part B

(Circle One)

1.	The applicant has a mild intellectual disability and a mental health disorder. If yes - the mental health disorder must be the primary diagnosis - please complete information on page 5	YES / NO
2.	The applicant has a drug/alcohol dependence -If yes please complete information on page 6	YES / NO

**If you would like to discuss this application, or require further information please call
 (716) 883-3331 and ask to speak to someone in the Adult and Senior Program.**

Please return this page to Compeer

PERSONAL INFORMATION

Application Date:	Applicant Name:		
Current Address:		Zip Code:	
Phone: Home:	Text? YES / NO		
Cell:			
Email:			
Health Insurance Type:	HMO or managed care:	Income source(s):	
Emergency Contact:			
Phone:		Relationship:	

Person requesting services:	
Address:	
Phone:	Relationship:

MENTAL HEALTH PROFESSIONAL INFORMATION

Name:	Title:
Agency:	
Address:	
Phone:	Ext:

ANY OTHER MENTAL HEALTH PROFESSIONAL/CASE MANAGER:

Name:	Title:
Agency:	
Address:	
Phone:	

Please return this page to Compeer

Compeer use only:

First name: _____ Last initial: ____ Township: _____ Enrollment date: _____

Program: _____ update date: _____

Date of Birth:	Age:	Gender:
Race:	Hispanic: Yes / No	Primary Language:
Military Service: Yes / No		
If Yes, what branch?		
Applicant's contact with family is: <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Never		Is applicant pregnant or parenting? Yes / No If yes, ages: _____ Grown Children? Yes / No Ages: _____
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Significant other/ Partner <input type="checkbox"/> Single <input type="checkbox"/> Widow/ Widower		Smoker? Yes / No If Yes, how many packs per day?
Living Situation: <input type="checkbox"/> Living Alone <input type="checkbox"/> Group Home <input type="checkbox"/> Aged Care Facility <input type="checkbox"/> Boarding House <input type="checkbox"/> With friends <input type="checkbox"/> Other (specify) <input type="checkbox"/> With family (specify)		Physical description:
Religion: Will this be a factor in choosing a Compeer volunteer? Yes / No		

Mental Health Information

Please include DSM diagnosis code.

Axis I: (Acute diagnosis)		DSM diagnosis code(s):
Axis II: (Personality disorders and developmental disabilities)		DSM diagnosis code(s):
Axis III: (Any relevant medical diagnoses)		
Axis IV: (Stressors)		
Axis V: (Global Assessment of Functioning)		
Previous psychiatric hospitalization? Yes / No		
If Yes, include dates, facility, length of stay: _____		
CSS eligible? Yes / No / Unsure (please circle one)		

Physical/Medical Limitations

Will the applicant need assistance to leave home with the volunteer? Yes / No If Yes, please describe: _____
Any dietary limitations or food allergies? Yes / No If Yes, please describe: _____
Does the applicant need assistance or supervision with basic self-care activities, including dressing, toileting, hygiene, and grooming? Yes / No If Yes, please describe: _____
Is the applicant able to independently get in and out of a vehicle? Yes / No If No, please describe: _____
Is the applicant taking medications? Yes / No If Yes, please list, and note how it may impact the Compeer friendship: _____ _____
Does the applicant have a history of alcohol or drug abuse? Yes / No If Yes, please describe: _____ If Yes, is this being addressed – please detail: _____ _____ _____ _____

Brief History

Employment background:	Educational background:	
Has the applicant ever been in trouble with the law? Yes / No If Yes, please describe: _____		
Reading Level:	Writing Level:	Good phone skills?
What support structures does the applicant have? (Example: friends, family, work) _____ _____ _____ _____		
Is the applicant isolated? Yes / No If Yes, please explain: _____ _____		

Describe personality/way of relating to others:

Why do you feel a Compeer would be helpful? (include goals and expectations of relationship)

What kinds of activities are pursued? (Include hobbies and interests)

Specific suggestions to guide the Compeer Volunteer in developing the relationship:

Would the applicant like to have contact with Compeer while they wait? (Circle all that apply)

E-mail newsletters phone calls none

Does the applicant use public transportation?
Yes / No

Is the applicant open to a volunteer who does not drive? Yes / No

Other means of transportation:

Applicant would like a Compeer volunteer who is:	<input type="checkbox"/> Any age <input type="checkbox"/> 18- 29 years <input type="checkbox"/> 30- 50 years <input type="checkbox"/> Over 50 years	<input type="checkbox"/> Any race <input type="checkbox"/> Same race <input type="checkbox"/> Other race:	<input type="checkbox"/> Any <input type="checkbox"/> Female <input type="checkbox"/> Male
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RELEASE OF INFORMATION

Date _____

Name: _____ DOB _____

In order to assist in assessment and to facilitate a match, I authorize Compeer of Greater Buffalo ("Compeer") to communicate in person, by phone, or in writing with the persons and/or organizations listed below, and I also authorize the persons and/or organizations listed below to communicate in person, by phone or in writing with Compeer.

I also specifically authorize the persons and/or organizations listed below to release the following information to Compeer - psychological, psychiatric, medical reports and treatment summaries. I likewise authorize Compeer to release treatment information to the persons and/or organizations listed below.

I understand this authorization is in effect as long as we are active with Compeer, although I may rescind it any time, upon written notice to Compeer.

Name of Referring Person _____

Name of Agency or Private Practitioner _____

Other _____

Applicant's Signature

Staff Member's Signature

Date

Date

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INFORMATION SHEET FOR CONSUMERS Rights and Responsibilities

(Applicant's copy)

- I have the right to have my privacy and confidentiality 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 visits before terminating.
- I understand that my Compeer friendship is one-to-one. My Compeer volunteer and I will not include other people in our visits, for at least three to six months, or longer if needed.
- I understand that activities we do should be free or low cost and what we would both like to do. I will pay for myself during outings.
- I will not attend any activities with the volunteer that include drugs, alcohol, or dangerous situations.
- 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 12 months, but it may.
- I understand that the volunteer is required to submit a monthly report to Compeer 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 person 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, phone number, email, or health professional changes.
- I understand that the Compeer friendship is made up of myself, the volunteer, the Compeer staff and my health professional.
- Joining Compeer is my choice.

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