259 Monroe Avenue
Rochester, NY 14607
(585) 546-8280
www.compeerrochester.org

Compeer Rochester

Dear Referring Provider,

Thank you for your interest in referring your client to Compeer Rochester. Attached you will find our updated 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 and appropriate for the program. We ask that you attach a psycho-social assessment of the client if you have one. You must complete the referral in its entirety, except in the case of a military youth, in which you can leave diagnostic information blank if there is none to be shared.

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, personality traits, interests, level of client need versus the level of experience of the volunteer, and geographical location.

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 combating the stigma and other challenges facing our youth, adults and families. We view our program as an adjunct to therapy and other support services. It cannot operate alone, so we look forward to partnering with you to meet the goals of your client.

Sincerely,

Dana Frame

Dana Frame
President

Compeer Rochester
Friendship | Wellness | Community

RESPONSIBILITIES OF REFERRAL SOURCE/MENTAL HEALTH PROFESSIONAL

- You must have contact with potential volunteers to help determine the best match for individuals 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 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 clients you refer, volunteers, and/or Compeer staff before and during the match.
- You must notify Compeer of any changes in your client's mental health, agency/mental health provider, or contact information.
- You must let us know if you close with clients 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 unless he or she has a mental health professional or some form of counseling. If you close out a client while he or she is still matched, Compeer staff will determine eligibility 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.
- 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 Compeer may also be able to provide your client with Home and Community Based Services **(HCBS),** if they are eligible and elect to participate in such.

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 client 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.

- 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 by him or her, or you as the provider.

- We will offer advocacy and other Family Support Services by our Family Mentor 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~

Compeer Rochester
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Criteria for Acceptance
Adult 1:1 Mentoring Program

Please complete this checklist prior to completing referral:

1.	Does client must 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
3.	Is client interested in socializing and spending time out in the community with a volunteer?	Yes	No
4.	Is client able to identify goals around overall wellness?	Yes	No
5.	If client is using a wheelchair or has other mobility challenges, is he/she independent with transfers?	Yes	No

If all above questions are answered "Yes," please proceed:

6.	Has client ever been convicted of a sexual or violent offense?	Yes	No
7.	Is client acutely suicidal?	Yes	No
8.	Is client diagnosed with a Substance Use Disorder?	Yes	No
9.	Has client been hospitalized in the past six months for a mental health concern?	Yes	No
10.	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:

11.	Is the referral completed in its entirety?	Yes	No
12.	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
13.	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. If your client does not meet the above Criteria, he or she may still qualify for other services at Compeer Rochester. Contact us for more information about our fee-for-service programs.

MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM- ADULT SERVICES

259 Monroe Avenue
Rochester, NY 14607-3632
Office: 585-546-8280
TTY: 585-546-7959
Fax: 585-325-2558
Website www.compeerrochester.org

Compeer Office Use Only:
Date Received:_____by_____
Date Logged In:_____by_____
Date Approved: _____ by _____
Referral Denied: _____by _____

CLIENT ID_____

PROGRAM DESIRED (CHECK ALL THAT APPLY)

- ❑**1:1 Mentoring Program** (long term match with volunteer)
- ❑**Supportive Partners for Recovery** (fee-for-service, goal-based, short term match with paid staff)
- ❑**CompeerCorps** (Veterans only, peer mentoring)
- ❑**Compeer Calling** (1:1 Supportive weekly phone contact)
- ❑**E-Buddy** (1:1 supportive e-mail contact)

REFERRAL DATE:

CLIENT INFORMATION

Client Name:	Date of Birth: ____/____/_____		
Current Address:	City:	State:	Zip:
Phone:	E-mail address:		

LIVING SITUATION

Lives with (self, spouse, parents, foster parents, relatives, friends, group home, in-patient, etc.)

_____

Names, relationship to client, and birth dates of those in same home (group home or in-patient need not complete)

Name:	Relationship:	Birth date:
Name:	Relationship:	Birth date:
Name:	Relationship:	Birth date:

EMERGENCY CONTACT

Name:	Relationship to Client:	
Phone (Day):	Address:	
Phone (Evening):	City:	Zip:

GOALS FOR COMPEER RELATIONSHIP/WELLNESS

Prevention:
Emotional & Social:
Physical Activity/Nutrition:

MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM- ADULT SERVICES

PSYCHOSOCIAL INFORMATION

Does the client have access to transportation? ❑Yes ❑No What type? ❑Car ❑Bus ❑Other_____ Are there any special needs for transportation? If yes, please explain (i.e. wheelchair access, etc.):
Current involvement in programs (e.g. Day treatment, work, volunteering, and community recreation) - please list:

INTERESTS/HOBBIES/ACTIVITIES		
❑Arts and Crafts:	❑Sports:	❑Movies:
❑ Cooking:	❑Outdoor Activities:	❑Drama:
❑Sewing:	❑ Church/Temple:	❑ Volunteering:
❑Reading:	❑Fitness Activities:	❑Music:
❑Animals:	❑ Dining Out:	❑Shopping:
Describe client's strengths and positive attributes:		
Are groups difficult for your client? ❑ Yes ❑ No		
How does your client handle frustration?		

DSM DIAGNOSIS – PROVIDE NAME AND CODE	
Primary:	Environmental Stressors:
Secondary:	
Medical Conditions:	SPMI? ❑Yes ❑No
Symptomatic Behaviors (What does the volunteer need to know?): ***PLEASE ATTACH PSYCHOSOCIAL REPORT, WHODAS AND/OR APPLICABLE ASSESSMENTS***	
Does client have any other medical conditions? ❑Yes ❑No If yes, please describe:	
Does client have any physical limitations? ❑Yes ❑No If yes, please describe	
Does client take medication(s)? ❑Yes ❑No	

MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM- ADULT SERVICES

CRIMINAL/LEGAL HISTORY

Does client have a history of illicit drug 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 documentation, dates and a detailed account of the history:
Has client ever been convicted of a felony or for any criminal activity? ❑Yes ❑No If yes, please describe and provide documentation, dates and a detailed account of the history:

MENTORING PREFERENCES: WHAT IS IMPORTANT TO YOUR CLIENT?

Is it important that the volunteer be a specific age, gender, religion, and ethnic background or have a specific quality? ❑Yes ❑No If yes, please specify:	
What would not be a good match?	
Does client smoke? ❑Yes ❑No	Does it matter to client if volunteer smokes? ❑Yes ❑No

REFERRING INFORMATION

Referring Provider		Title:	
Agency:			
Address:		City:	Zip:
Phone:	Fax:	**Required** Email:	
Preferred Method of Contact: ❑E-mail ❑Mail	Relationship/role with client:	Type of treatment	
Primary contact for Compeer Program? ❑Yes ❑No			

If NO, please list information for primary contact

Primary Provider		Title:	
Agency:			
Address:		City:	Zip:
Phone:	Fax:	**Required** Email:	
Preferred Method of Contact: ❑E-mail ❑Mail	Relationship/role with client:	Type of treatment	

1. Is client **HARP** eligible? ❑Yes ❑No ❑Unknown
2. Does client have a Health Home Care Manager (**HHCM**)? ❑Yes ❑No ❑Unknown

If YES to question 2, complete the following

Name:		Title:	
Agency:			
Address:		City:	Zip:
Phone:	Fax:	**Required** Email:	

MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM- ADULT SERVICES

1. Gender:
___Male
___Female
___Transgender Male to Female
___Transgender Female to Male
___Other _____
___Unknown

2. Race: *(check one)*
___White
___Black / African American / Afro-Caribbean
___Asian
___American Indian / Alaska Native
___Native Hawaiian / Pacific Islander
___Other _____
___Unknown

Hispanic/ Latino Indicator
___Not Hispanic/Latino
___Mexican
___Puerto Rican
___Cuban
___Dominican
___Ecuadorian
___Origin Not Specified
___Unknown

3. Veteran Status – Client
___Yes, Now on active duty
(includes Reserves or National Guard)
___Yes, In past but not now (Veteran)
___Yes, Current active status unknown
___No, Training for Reserves or National Guard Duty
___No, Never served in military
___Unknown

3a. Combat Service – Client
___Yes
___No
___Unknown

3b. Veteran Status – Client's Spouse/Partner
___Yes, Now on active duty (includes Reserves or National Guard)
___Yes, In past but not now (Veteran)
___Yes, Current active status unknown
___No, Training for Reserves or National Guard Duty
___No, Never served in military
___Unknown

3c. Veteran Status – Client's Parent/Legal Guardian
___Yes, Now on active duty
(includes Reserves or National Guard)
___Yes, In past but not now (Veteran)
___Yes, Current active status unknown
___No, Training for Reserves or National Guard Duty
___No, Never served in military
___Unknown

4. Living Situation: *(check one)*
___Private Residence (owned or mortgaged)
___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)
___Family Care
___Foster Home (C&Y clients)
___Residential Treatment Facility
___SRO (mental health)
___Supported Housing/Apartment
___Transient/Homeless
___Other_____
___Unknown

5. Employment Status
___Full Time Employment Where:_____

___Part Time Employment Where:_____

___Sporadic or casual employment for pay
___Non-paid work position (volunteer)
___Not in Labor Force: looking for work
___Not in Labor Force: retired, homemaker, student
___Not in Labor Force: disabled, psychiatric inpatient,
___Not in Labor Force: other _____

6.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

7. 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

8. Health Insurance Coverage:
___Medicaid
If Medicaid, Is it Managed Care ?_____

___Medicare
___Private Insurance (BC/BS, MVP, Aetna ,Etc)
___Child Health Plus
___ Family Health Plus
___Other : _____

MENTAL HEALTH PROFESSIONAL'S REFERRAL FORM- ADULT SERVICES

9. Marital Status:
___Never Married
___Married
___Widowed
___Separated
___Divorced/Annulled
___Unknown

10. Education: *(check last grade completed)*
___No Education
___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

11. Primary Language:
___English
___Spanish
___Sign Language
___Other _____

12. Aggregate Household Income
___Less than $13,200
___$15,000 - $24,999
___$25,000 - $44,999
___$45,000 - $74,999
___$75,000 and Up
___Unknown

13. Religion:
___ Catholic
___Baptist
___Protestant
___Jewish
___Buddhist
___Islam
___Other_____
___Unknown

14.Additional Disabilities: *...Please Explain*
___No Disabilities
___Developmental_____
___Mental retardation:_____
___Alcohol:_____
___Drugs:_____
___Mixed Substance:_____
___Blind:_____
___Hearing Impaired:_____
___Ambulation Impairment:_____
___Other:_____
___Unknown

15. 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 Criminal Justice Status
___Unknown if client has a criminal or juvenile justice status

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.

Please list any medications and/or medical conditions not already mentioned in referral:

_____

_____

_____

Medical coverage information:

Physician's Name_____ Office Phone _____- _____ -_____

Office address: _____

Preferred Hospital (optional)l: _____

Insurance Company:_____ Policy # (optional) _____

WAIVER: I realize that I must have proper medical insurance, including coverage for hospitalization. I understand that participating organizations do not provide accident insurance coverage. I further understand that I am participating at my own risk and assume the risk of injury. I am aware that the activities in which I 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 me in connection with this activity.

_____ _____

Client's Signature Date

_____

Client's Name (print please)

_____

Witness's Signature

Compeer Rochester
Friendship | Wellness | Community

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: ( ) Patient /Client ( ) 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.

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.

Client Signature: _____ Date: _____

Staff/Mental Health Professional Signature: _____ Date: _____

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

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**.

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.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **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).

☐ **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***.

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** 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)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: _____; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.