Welcome to the Compeer Program!

Adult Referral Packet

1. A Mental Health Professional and the individual who is in need of services should complete applications.
2. Please read and keep the application guidelines. (Mental Health professional)
3. Please fill out the **eligibility criteria form.** (Return this to Compeer)
4. Please fill out the **page application.** (Return this to Compeer)
5. Please review the information sheet for consumers. (For the applicant)
6. Please sign and witness the **release of information form.** (Return this to Compeer)
7. Please make a copy of the completed, signed application for your records. Return the required forms to address below, or can fax to: 740-522-4464.

Attention: Compeer Coordinator

MHA of Licking County

65 Messimer Drive

Newark, OH 43055-1881

Feel free to call Compeer Coordinator at **740-788-0303,** if you have any questions.

Once we have received the completed application, you will receive a "Welcome to Compeer" letter.

Thank you for your interest in the Compeer Program.

Please Return Pages 3-6 to Compeer.

Application Guidelines For Professional Mental Health Staff

Referral procedures/Guidelines

1. **Factors to consider for an individual's appropriateness as a referral to the Compeer program:**
   - Willingness to be matched to a Compeer volunteer (a referred individual should be informed about Compeer program guidelines before meeting a volunteer.)
   - Need for the kind of social interaction a volunteer friendship provides.
   - Referrals of "difficult cases" should first be discussed with Compeer staff to ascertain appropriateness and to determine the type of volunteer best suited for the match.
   - Information judged too sensitive to be disclosed on the referral form can be discussed with Compeer staff at this point.

2. **Referral forms should be filled out carefully and completely.**
   - All information requested is essential to facilitate the matching process and is, of course, confidential. Referral forms are available from the Compeer office.
   - Positively reflecting the referred individual's personality, as well as demonstrating a need and desire for a volunteer, can enhance a client's chance of being matched.
   - Pertinent information, both psychiatric and medical, should always be disclosed-either in conversation with Compeer Coordinator or on referral form.

Therapist Responsibilities

1. **Therapists should meet face to face with the volunteer selected to be matched.**
   - While all volunteers are interviewed, screened and trained by Compeer staff before meeting the referring therapist, the therapist is regarded as the final screening process of volunteer appropriateness. If you have any questions about a volunteer, call the Compeer Coordinator to discuss your concerns.
   - To avoid disappointment, it is best not to inform the referred individual about a potential volunteer until after the volunteer/therapist meeting.
   - If the match is considered appropriate, the referring therapist is responsible for giving specific instructions and guidelines to the volunteer regarding the Compeer match relationship.
2. The volunteer and referring therapist should communicate periodically to discuss and evaluate the progress of the relationship. Volunteers need and respect guidance, advice and that will help them to act as an adjunct to treatment. A volunteer who receives periodic feedback and feels supported by the therapist is more likely to meet the therapist's goals and better serve his/her friend.
3. Any pertinent information such as change in the referred individual's status, change in address, change in therapist, etc. should be reported to the Compeer office and volunteer.

Compeer Program Responsibilities

1. Compeer staff will interview, screen and train, volunteers prior to the therapists/volunteer meeting.
2. Compeer staff will monitor the Compeer relationship and will advise the therapist if questions/ concerns may arise.
3. Monthly reports submitted by the volunteer to the Compeer office will be sent to the referring therapist.
4. The Compeer program will offer ongoing support and training for volunteers and monthly group enrichment activities for matches.

Compeer Referral Form

Mental Health America of Licking County
65 Messimer Drive
Newark, Ohio 45055
PHONE:740.522-1341

Eligibility Criteria for the Compeer Program

Part A (Circle one)

1. The applicant's prime diagnosis is an identified mental health disorder. Required. **YES/NO**
2. The mental health professional completing this form agrees to support the friendship by talking to the applicant, volunteer and Compeer staff, prior to and, if necessary, during the 12 month friendship as outlined in the application and attached matching procedures. **YES/NO**
3. The applicant is in the recovery stage of their illness and **not acutely suicidal.** **YES/NO**
4. The applicant is in the recovery stage of their illness and **not physically or verbally aggressive.** **YES/NO**
5. The applicant is in the recovery stage of their illness and **does not have thoughts to harm self or others**. **YES/NO**
6. The applicant lacks friends, has limited social support and has difficulty accessing "mainstream" activities and social life. **YES/NO**
7. The applicant is asking for more social contact and is willing to participate in the Compeer program. **YES/NO**
8. The applicant understands and respects the limits of the Compeer relationship as a two-way friendship-as outlined in the Consumers Rights and Responsibilities. **YES/NO**
9. The applicant is 18 years old or older. **YES/NO**

If you answered "yes" to all of the criteria above, please proceed with the application. If you answered "no" to one or more of the criteria above, please contact Compeer Coordinator, Kristen Frame at 740-788-0303 prior to completing this form.

Part B (Circle one)

1. The applicant has a mind intellectual disability and a mental health disorder. **YES/NO**
2. Is the applicant able to leave home unassisted with the volunteer? **YES/NO**
3. Is the applicant able to independently get in and out of a vehicle? **YES/NO**
4. The applicant has a drug/alcohol dependence-If yes, complete information on page 4. **YES/NO**

If you would like to discuss this application, or require further information, please call Compeer Coordinator Kristen Frame at 740-788-0303.

(Please return this page to Compeer)

Page 3

Personal Information

Application Date: _____ Applicant Name: _____

Current Address: _____

Access to a phone: **YES/NO** Phone: Home: _____ Cell: _____

Email: _____ Date of Birth: _____ Gender: _____

Age: ___ Race: _____ 508 Eligible: _____ Medicaid Client: **YES/NO**

Reliable Transportation: **YES/NO**

Contact with family: Frequent Occasional Never (circle)

Ages of Children (if any): _____

Living Situation: lives with…

_____

Medical Information

Primary Diagnosis: _____

DSM-IV code: _____ Additional Diagnosis: _____

Previous Psychiatric Hospitalization (dates and length of stay):

_____

_____

_____

Symptomatic Behaviors:

_____

_____

Psychotropic medications: **YES/NO** Other medications: **YES/NO**

Side Effects to be aware of: _____

Seizure activity: _____ _ Substance abuse: _____ Visual impairment: _____

Diabetes: _____ Hearing impairment: _____ Dental problems: _____

High blood pressure: _____ Kidney problems: _____

Heart Disease/Stroke history: _____

Allergies or Dietary limitations: _____

Alcohol and Drug Use

Does the applicant have a history of drug or alcohol addiction and/or in recovery program? **YES/NO**

Please specify: _____

_____

Is this being addressed (please detail)?

_____

(Please return this page to Compeer)

Page 4

Current Activities

Day Treatment: **YES/NO**	Student: **YES/NO**	Volunteer Work: **YES/NO**
Employment: **YES/NO**	Sheltered Employment: **YES/NO**	Retired: **YES/NO**
Homemaker: **YES/NO**	Other: **YES/NO**	Car: **YES/NO**
Availability: Days: **YES/NO**	Evenings: **YES/NO**	Weekends: **YES/NO**

Mental Health Support Services

Case management: **YES/NO**	Transportation: **YES/NO**	Case Manager: **YES/NO**
Therapist: **YES/NO**	Psychiatrist: **YES/NO**	Other: **YES/NO** _____

Education: _____

Past Employment: _____

Mental Health Professional Information

Name: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Goals or reasons for referral: _____

_____

_____

_____

Additional Comments/suggestions: (use additional space if needed)

_____

_____

_____

_____

_____

(Please return this page to Compeer)

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Consent for Release of Information

To Enter the Compeer Program

_____ to release/to share with:

(Name of Agency or Professional)

_____

(Address)

_____

(City, State, Zip)

Compeer Program
65 Messimer Drive
Newark, OH 43055

information, which is included on the Compeer Client Referral Forms.

I, _____, voluntarily enter the Compeer program with the approval
(Client Name)

of _____.
(Case Manager/Therapist/Doctor)

I give my case manager/therapist/doctor consent to release and share pertinent information to the COMPEER STAFF and to potential volunteers regarding my participation in the program (for the purpose of enrolling me in the Compeer program).

I understand that the commitment to the Compeer Program is for ONE YEAR from the date I am matched with my Compeer volunteer friend.

Signed: _____
(Client)

Witness: _____
(Case manager/ Therapist/Doctor)

Date: _____

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 and role model. The volunteer is not a mental health professional.
- 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 situations. I will not engage in the 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 that the friendship will end after twelve 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 contact we have had. If I prefer, we can complete this form together.
- I understand that if I make any threats to harm myself or somebody else that the volunteer has the 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, 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 Compeer Coordinator in advance.