Compeer

Mental Wellness Starts With Friendship

Compeer Friendship Program
Mental Health Association in Butler County
140 North Elm Street, Suite A
Butler, PA. 16001

CLIENT REFERAL INFORMATION (To be completed by the referring agency)

NAME: _____

ADDRESS of RESIDENCE: Street_____

Apt. #____ City_____ State _____ Zip_____

MAILING ADDRESS: Street_____ P.O. Box_____

City_____ State_____ Zip_____

TELEPHONE: _____e-mail _____Date of Birth: _____

Is Transportation Available? ___ [YES] ___ [NO] Own a car? ___[YES]____[NO]

Age_____ Race_____ Religion/Faith_____ Height_____ Weight _____

Are you a Military Veteran? _____ Branch of Service _____ Discharge Date _____

____Married ____Single _____Divorced _____Separated _____Widow/Widower

Number of Children_____ Ages of Children_____

Contact with Family: ____Yes ____No Family or Friend _____
Contact Information /Telephone: _____

___Spouse _____ Parent _____Child _____Other_____

Source of Income, if known: (e.g., SSI, Social Security, Veteran, Rentals, Pension, Wages)

Educational Background: _____
Employment History: _____

Current Hobbies or Special Interests: _____

_____

(Please give information that will assist in making a **friendship connection** with a Compeer volunteer.)

COMPEER = Mental health *recovery through the healing power of friendship.* (Page 1 of 3)

Social Functioning/Personality: _____

Positive Attributes: _____

Suggestions to guide the COMPEER volunteer in developing a friendship:

_____

Preference to: Age_____ Race_____ Smoker: ____yes ____no

Client Availability: Daytime_____ Evening_____ Week-end_____ Anytime_____

PSYCHIATRIC-D&A - Background Information

Primary Diagnosis_____

Secondary Diagnosis_____

Physical Limitations/Medical Conditions_____

Symptomatic Behaviors_____

Does client have dual diagnosis? …MH/ID…MH/D&A (circle one) _____Yes _____No

Is client currently under D & A treatment? _____Yes _____No

Has client ever been convicted of a felony or a criminal act? _____Yes _____No

Please give a brief description of the client's stability, cooperativeness, and desire to participate in the COMPEER Friendship Program:

_____

_____

Has this client been: Hospitalized? _____Yes _____No
Residential care? _____Yes _____No
Transitional rehabilitation? _____Yes _____No

Has the client been hospitalized for mental health treatment? Discharge Date: _____

_____Torrance _____Butler _____VA Medical Center _____Other

Explain: _____

Please rate the "Priority of Need" for support through friendship: 1 = highest – 10 = low

1 ----- 2 -----3 -----4 -----5-----6-----7-----8-----9 -----10 Reason: _____

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COMPEER: *Volunteers using the power of friendship to help people transitioning through a psychiatric disability live happier, healthier lives."*

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REFERRAL submitted by: _____

TITLE: _____ PROVIDER/AGENCY: _____

ADDRESS: _____ ZIP: _____

TELEPHONE: _____ Best time to call: _____

Primary therapist (if different from above): _____

AGENCY / PROVIDER _____

ADDRESS _____ ZIP: _____

TELEPHONE: _____ EMAIL: _____

It is understood by the referring Provider Agency that the applicant will be placed on a ***list of referred clients waiting for a friendship connection.*** At times volunteers from the community are not immediately available. Compeer volunteers provide encouragement through trust. Our goal is to experience successful, mentoring relationships with each Compeer connection.

All information on this referral form is held confidential with HIPAA compliance.

DATE of Referral: _____

Please be sure all three pages are completed! Thank you very much!

Please return this application to:
Compeer Friendship Program
140 North Elm Street, Suite A
Butler, PA. 16001

COMPEER is *Making Friends and Changing Lives*

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NREPP Included in SAMHSA's National Registry of Evidence-based Programs and Practices

United Way

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RELEASE OF INFORMATION Compeer Friendship Program

Mental Health Association in Butler County

140 North Elm Street, Suite A

Butler, Pennsylvania 16001

Fax: 724-287-7090 Phone: 724-287-4083

I, _____, do hereby consent to and authorize _____ to disclose information to the

_____Compeer Program Staff/Volunteer

_____Mental Health Advocate or Referring Agency

_____Other_____

Information from my case records. I understand the reason for this *Release of Information* is to facilitate program guidelines, and to allow program coordinators and advocates to discuss information with collaborative agencies, providers, or others for the purpose of helping with a specific problem or complex situation.

I understand that information discussed in consultation and networking with services include:

Social Services_____ Therapy Notes_____ Peer Services_____ Compeer_____

Substance Abuse (Drug / Alcohol) _____ Hospitalizations_____ Case Management_____

Other (please explain):_____

This statement must be upon entering the Compeer Program or programs at the Mental Health Association and may be revoked at any time. This Release of Information *will remain confidential and in compliance with the Mental Health Association's HIPAA policy guidelines. This* Release of Information *will remain in force for a reasonable period of time & may be updated periodically.*

Signed_____

Witness_____

Date_____

NREPP
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