



Spreading Hope, Spurring Action, Supporting Families, Saving Lives!

**COMPEER PROGRAM
REFERRAL PACKET**

3701 Latrobe Drive, Suite 140
Charlotte, NC 28211
Phone – 704.365.4380
Fax – 704.365.9973



Mental Wellness Starts With Friendship

ABOUT COMPEER

What Is The Compeer Program?

Compeer is a Program of Mental Health America that matches volunteers in one-to-one friendships with men and women who receive mental health services in Mecklenburg and Cabarrus County and its contract agencies. Program goals are to provide social, leisure, and recreational opportunities that decrease loneliness and isolation.

Who Are Compeer Volunteers?

Volunteers are individuals, eighteen and over, from all walks of life. Anyone who is listed in the Sexual Abuse Registry will be precluded from volunteering for Compeer. Additionally all volunteers will submit to a background check including for criminal history. They are people who enjoy companionship and helping others. Many of them have had experiences with loneliness and difficult times in their own lives, which provides them with a special understanding of the Compeer friendship. They are screened, trained, and matched by Compeer and the referring case manager. Volunteers are supportive friends; they are not counselors or therapists.

What Do The Volunteers And Friends Do Together?

Volunteers and friends meet once a week for an hour or every other week for two hours for one year. They participate in activities that both people enjoy. Some of the activities might include things like:

Movies	Eating out	Shopping	Playing cards
Bowling	Sporting events	Putt Putt Golf	Hiking

From time to time Compeer sponsors parties or events for matches to attend. And whenever possible, Compeer keeps gift certificates and tickets on hand for activities in the community that matches can do together.

How Do I Get A Compeer Volunteer?

Your participation in the Compeer Program is voluntary. Once you and your case manager talk about the Program and decide whether you meet the admission criteria, your case manager will make a referral to Compeer on your behalf. Your name will go into a pool of referrals. Compeer will only make **same sex** matches. Compeer **does not match** on a first come first serve basis, so there may be a waiting period before you actually get matched with a volunteer. Compeer will make every effort to match you as quickly as possible.

ADMISSION CRITERIA

1. The Compeer contract specifies that Mental Health America of Central Carolinas (MHA) will accept referrals from designated service providers.
2. Individual must be at least 18 years of age, and have a diagnosis of a severe and persistent mental illness.
3. Referral will be made in concert with their adult community support coordinator to the Compeer Program or a person may self-refer.
4. Individual must have a desire and ability to participate in full range of activities and have consistent respect and tolerance for others.
5. Individuals that are on the sexual abuse registry will not be eligible for Compeer.
6. Individual will not be exhibiting any assaultive or destructive behaviors.
7. Individual will not currently be abusing alcohol or other substances.
8. Individual will not currently be exhibiting antisocial behaviors, i.e., sexually acting out, stealing, and/or cursing.
9. Individual will have a willingness to take medication prescribed by physician in concert with the consumers input and agreed upon by both parties. Psychotic and/or behavioral symptoms will be under control.
10. The physician of record must clear referral/individual in order to participate in program.
11. The Compeer Coordinator and community support coordinator staff will handle all inappropriate behaviors on an individual basis. Any infractions outlined in items 4 through 8 may result in being discharged from the Compeer program and staffed with case manager for case disposition.
12. Individuals must consent to a background screening to participate in the program.
13. Any other (besides appearing on the sexual abuse registry) prior criminal history will be reviewed by the Compeer Coordinator, Compeer Director and MHA's Executive Director to determine appropriateness for participation.

Referral Procedures

1. Discuss and explain the program to the people you would like to refer. Review the "About the Compeer Program", "Admission Procedures," and the "Friend Agreement" handouts with the individual. Include as much information as possible to ensure an appropriate match.
2. Make only appropriate referrals to Compeer (see admission criteria).
3. Invite Compeer staff to meet the person at the time of the referral.
4. Fax (704.365.9973) or mail the Referral form, Friend Agreement, and a Release of Information to Compeer (MHA 3701 Latrobe Dr., Suite 140, Charlotte, NC 28211). Referrals will not be accepted until all forms are received.
5. Meet and screen the potential volunteer prior to the match. (It's best not to inform the referral about the volunteer until the match is definite).
6. Provide the volunteer with any information about the person that may facilitate the relationship.
7. Participate in introductory meeting with referral, the volunteer, and Compeer staff (optional).
8. Monitor the person's satisfaction with the match and be open to talking or meeting with the volunteer as necessary to support the friendship.
9. Review monthly reports from volunteers.
10. Keep Compeer updated on any changes in referral's status, address change, concerns, etc.
11. Complete annual survey.

REFERRAL FORM

Referral Date: _____

Demographic Information

Referral's Name: _____ Date of Birth: _____

Age: _____ Race: _____ Gender: _____ Marital Status: _____

Address: _____ Zip: _____

Who do you live with? (self, spouse, roommate, group home, other) _____

Home Phone: _____ Work Phone: _____

Place of employment: _____

Ages of children: _____ Do you smoke? _____

Educational Background: _____

Do you have use of a car? _____ Military service? _____

Email address: _____

Social Security
number: _____

Clinical Information

Diagnosis: _____

Symptomatic/safety concerns: _____

Physical limitations/Medical conditions: _____

Have you ever been convicted of a crime (except minor traffic violations)? Yes No

Describe nature of crime, date of charge, and disposition: _____

Are there any misdemeanor/felony charges pending against you currently? Yes No
Describe nature of charge _____



Friend's Interest

Please check any consumer skills, interests, activities, or hobbies:

<i>Interests, Activities, Hobbies</i>		
<input type="checkbox"/> Arts:	<input type="checkbox"/> Sports:	<input type="checkbox"/> Movies:
<input type="checkbox"/> Crafts:	<input type="checkbox"/> Outdoor Activities:	<input type="checkbox"/> Drama:
<input type="checkbox"/> Sewing:	<input type="checkbox"/> Gardening:	<input type="checkbox"/> Games:
<input type="checkbox"/> Reading:	<input type="checkbox"/> Fitness Activities:	<input type="checkbox"/> Music:
<input type="checkbox"/> Animals:	<input type="checkbox"/> Dancing:	<input type="checkbox"/> Shopping:
<input type="checkbox"/> Self Image Enhancement	<input type="checkbox"/> Volunteering:	<input type="checkbox"/> Computers
<input type="checkbox"/> Collecting:	<input type="checkbox"/> Cooking/nutrition	<input type="checkbox"/> Budgeting/Checkbook

Other _____

Match Preferences

Compeer will only make **same sex** matches, however please indicate any preference consumer has for his/her match regarding:

Age _____ Race _____ Religion _____

When is consumer available? Daytime _____ Evenings _____ Weekends _____

Does Compeer have the friend/referral's permission to send newsletters, event notices, and other correspondence to the consumer's home address? Yes _____ No _____



Goals for the Relationship

1. _____
2. _____
3. _____

Referral Source Information

Submitted by: _____

Title: _____

Location: _____

Phone: _____

Referral Reminders

1. Please have referral review and sign Compeer Friend Agreement.
2. Please have referral sign a Release of Information.
Referral will not be matched without a release. Send referral packet and release to: Fax: 704.365.9973 or mail: Mental Health America/Compeer, 3701 Latrobe Dr., Ste. 140, Charlotte, NC 28211.
3. Contact Compeer at 704.519.2332 to schedule a time for the Coordinator to meet the referral.
4. Keep Compeer posted of any changes in information about the person and/or their referral status.

Household Income: \$0 to \$9,999____ \$10,000 to \$14,999____ \$15,000 to \$24,999____
 \$25,000 to \$34,999____ \$35,000 to \$49,999____ \$50,000 to \$74,999____
 \$75,000 to \$99,999____ \$100,000 to \$149,999____ \$150,000 to \$199,999____
 \$200,000 or more____



COMPEER FRIEND AGREEMENT

____ I understand that Compeer is a program of Mental Health America of Central Carolinas, and I have received information about Compeer, its goals, and procedures.

____ I will spend at least one hour each week or two hours every other week with my Compeer volunteer.

____ I am willing to participate in the Compeer Program for at least one year.

____ I will comply with the Compeer Program guidelines, which prohibit the use of alcohol or other non-prescription drugs when I am with the volunteer.

____ I understand that overnight or out of town trips with my volunteer, must be approved by my Case Manager and the Compeer Coordinator.

____ I will report any concerns about the volunteer to my Case Manager and the Compeer Coordinator.

____ I understand that volunteers are required to inform Compeer and my Case Manager about any serious concerns regarding my welfare.

____ I understand that my involvement with my Compeer friend may be terminated if deemed necessary by Compeer staff.

____ I agree to the release of any information between Compeer staff, Mecklenburg County staff, and Compeer volunteers.

****I would like to allow my Compeer Volunteer to participate as a member of my treatment team.**

YES____ **NO**____

Compeer Referral

E-mail address____

Date Signed

Case Manager

E-mail address____

Date Signed



Compeer Friend Emergency Data Sheet

Friend Name: _____
First Last MI

Address: _____
Street City/State Zip

Home Phone #: _____ Cell Phone # _____

In event of emergency contact:

First Last MI

Address: _____
Street City/State Zip

Home Phone #: _____ Other Phone #: _____

Community Support Coordinator emergency # _____

Medical Insurance: Yes No Type of Insurance:(HMO/PPO/Other) _____

Allergies if known: _____

Physician: _____

Address: _____
Street City/State Zip

Office Phone #: _____

Hospital Preference: _____

* Medications are listed on the referral form.



Friend: _____

Date of Birth: _____

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

Agency, Organization, or Individual	Agency, Organization, or Individual
Name: _____	Name: Mental Health America of Central Carolinas
Address: _____	Address: 3701 Latrobe Drive
City, State, Zip: _____	City, State Zip: Charlotte, NC 28211
Phone: _____	Phone: 704 519-2332
Fax: _____	Fax: 704-365-9973

I consent to the above-named agencies, organization, or individuals to release, exchange, and/or communicate with one another the information that is listed below. I understand that the information released may include information regarding HIV/AIDS.

This data shall include: (Consumer must initial all that apply)

- _____ Screening and/or Admission Assessment Evaluation
- _____ Treatment (Service) Plan/Diagnosis
- _____ Discharge Summary
- _____ Case Management Assessment/Plan
- _____ Psychiatric and/or Psychological Evaluation
- _____ Progress (Service) Notes: Dates from _____ to _____
- _____ Treatment Report from other Agencies/persons (specify): _____
- _____ Medication History
- _____ Other: _____

Referral/friend must initial if any of the above data contains substance abuse information:

_____ I understand that my records are protected under the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation.

I understand this information will be used for: _____

I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent will terminate upon _____ (mm/dd/yy) (not to exceed one year from date of signature), or specified event or condition _____, whichever is earlier.

Friend
Date _____

Legally Responsible Person (when required)
Date: _____



COMPEER FRIEND'S RIGHTS AND EXPECTATIONS

RIGHTS

You have the right to.....

- privacy and confidentiality.
- be treated with dignity and respect.
- not be taken advantage of, free from abuse, and being treated fairly.
- ask questions and receive answers from Compeer staff and volunteers.
- be told when and why services will end.
- accept or refuse services.
- honest and open communication at all times.
- to suggest and choose or refuse activities.
- to say no and to make complaints without the fear of reprisal.

EXPECTATIONS

You should expect from your Compeer experience....

- friendship!!!
- properly screened and trained Compeer volunteers and staff.
- monthly Group Event opportunities (for all participants matched and unmatched).
- regular contact from your Compeer volunteer.
- meetings scheduled in advance.
- timely and consistent contact from your Compeer volunteer.
- regular communication.
- "menu" of specific choices of activities on a regular basis.

Compeer Friend Signature _____



Participation Waiver

In consideration for participating in any Compeer Event, I assume responsibility for all my actions while at Mental Health America of Central Carolinas, traveling to and/or from any such facility, or engaged in an activity under the supervision of my adult team leader, and/or the Mental Health America of Central Carolinas, ParentVOICE and Compeer program staff and volunteers.

Furthermore, I will not hold the Mental Health America of Central Carolinas, ParentVOICE and Compeer programs, the Board of Directors and their officers, employees and agent and volunteers for any loss, personal injury, accident, misfortune or damage to myself or my property, with the understanding that reasonable precautions shall be taken to ensure the health and safety of myself and my property.

I am signing this Agreement freely, voluntarily and competently and am at least eighteen (18) years of age.

Signature of Participant

Printed name

Date

Parent or Guardian Consent Form

I, the parent or guardian of _____, give my voluntary consent to his/her participation in the Mental Health America of Central Carolinas, ParentVOICE and Compeer programs.

I hereby release the Mental Health America of Central Carolinas, the State of North Carolina, the Board of Directors, and their officers, employees and agents from any and all liability resulting from events beyond control.

In the event of an accident, injury, or illness, the above stated and its agents do not assume any responsibility or obligation to provide financial assistance or other assistance, including but not limited to, medical, health, or disability insurance, in the event of an accident, injury, illness, death or property damage. In the event of an accident, injury, or illness, the above as stated and its agents will make every effort to contact parent/guardians immediately if necessary.

Furthermore, I release the Mental Health America of Central Carolinas, the State of NC, the Board of Directors and their officers employees and agents and volunteers for any loss, personal injury, accident, misfortune, or damage to the above name or his/her property, with the understanding that reasonable precautions shall be taken to ensure the health and safety of the above named.

Signature of Parent/Guardian

Date

Printed Name of Parent

Parent's Phone Number