



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

**COMPEER PROGRAM
REFERRAL PACKET**

3701 Latrobe Drive, Suite 140
Charlotte, NC 28211
Phone – 704.365.3454
Fax – 704.365.9973



ABOUT COMPEER

What is the Compeer Program?

Compeer is a program of Mental Health America (MHA) that matches volunteers in one-to-one friendships with men and women in adult case management with local mental health service providers. By providing a social outlet for referrals, volunteers help to bridge the gap between clinical services and the support of family and friends. The program goals are to provide social, leisure, and recreational opportunities that result in decreased loneliness and isolation.

Who are Compeer Volunteers?

Volunteers are individuals, eighteen and over, from a variety of different backgrounds. 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:

Movies
Shopping
Bowling
Putt Putt Golf

Eating Out
Playing Cards
Sporting Events
Hiking

Once or twice a month Compeer sponsors parties or events that you can attend. Whenever possible, Compeer keeps gift certificates and tickets on hand for activities in the community that matches can do together.

How can I get involved?

Contact the Mental Health America of Central Carolinas, Inc. Compeer Program at:

Phone: (704) 365-3454 ext. 217

-or-

Email: agarlins@mhacentralcarolinas.org

ADMISSION PROCEDURES

ADMISSION CRITERIA

1. The Compeer contract specifies that Mental Health America of Central Carolinas (MHA) will accept referrals from designated service providers only.
2. Referrals must be at least 18 years of age, and have a diagnosis of a severe and/or persistent mental illness.
3. Referrals will be made in concert with their adult community support coordinator to the Compeer Program; or, a person may self-refer.
4. Referrals must have a desire and ability to participate in a full range of activities and have consistent respect and tolerance for others.
5. Referrals will not be exhibiting any assaultive or destructive behaviors.
6. Referrals will not currently be abusing alcohol or other substances.
7. Referrals will not currently be exhibiting antisocial behaviors, i.e., sexually acting out, stealing, and/or cursing.
8. Referrals will have a willingness to take medication prescribed by physician in concert with your input and agreed upon by both parties. Psychotic and/or behavioral symptoms will be under control.
9. The physician of record must clear you in order to participate in the program.
10. The Compeer Coordinator and community support coordinator staff will handle all issues, questions, or concerns 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.
11. Any prior criminal history will be reviewed by the Compeer Director with MHA's Executive Director to determine appropriateness for participation.

REFERRAL PROCEDURES

1. Discuss and explain the program to the individual you would like to refer. Review the "About the Compeer Program", "Admission Procedures," and the "Friend Agreement" handouts with the individual you are referring. 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 individual 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 (3701 Latrobe Dr., Suite 140, Charlotte, NC 28211). Referral packets 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 individual about the volunteer until the match is definite).
6. Provide the volunteer with any information about the individual that may facilitate the relationship.
7. Participate in introductory meeting with referred individual, the volunteer, and Compeer staff (optional).
8. Monitor the individual'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 only per request with the approval from the volunteer and Compeer Coordinator.
10. Keep Compeer updated on any changes in the individual's status, address change, concerns, etc.
11. Complete annual survey.

REFERRAL FORM

Referral Date: _____

Demographic Information

Friend 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: _____

Does the friend have use of a car? _____ Military service? _____

Clinical Information

Diagnosis: _____

Medications: Are you currently taking any medications that limit your activities, or that you need to take special precaution with? If so, what precautions need to be considered (for example: avoid prolonged sunlight; use sunscreen when outside)? _____

Symptomatic/Safety concerns: _____

Physical limitations: _____

Clinical Information (Continued)

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 _____

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 are you available? Daytime _____ Evenings _____ Weekends _____

Does Compeer have the Referral's permission to send newsletters, event notices, and other correspondence to their home address? Yes _____ No _____

Interest

Please check any 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 _____

Personality Description

Please give a description of the person include their strengths, unique personality traits, behavioral patterns, ways of interacting, communication style, challenges, etc. Be as specific as possible. Feel free to include additional pages if necessary.

Goals for the Relationship

1. _____
2. _____
3. _____

Referral Source Information

Submitted by: _____

Title: _____

Location: _____

Phone: _____

Referral Reminders

1. Please have the Referral review and sign Compeer Friend Agreement.
2. Please have them sign a Release of Information. ***Referrals will not be matched without a release form.*** 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 704.365.3454 to schedule a time for the Coordinator to meet the Referral.
4. Keep Compeer posted of any changes in information about the Referral's status.

COMPEER FRIEND AGREEMENT

____ I understand that Compeer is a program of the 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 Director.

____ 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_____

Individual

E-mail address_____

Date Signed

Case Manager

E-mail address_____

Date Signed



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: 704-365-4380
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: (Referral 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.
- 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.

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