



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

**CLIENT REFERRAL 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

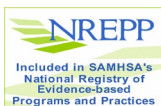
Has the client been hospitalized for mental health treatment?    Discharge Date: \_\_\_\_\_

\_\_\_\_\_ 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: \_\_\_\_\_





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

+++++

**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.**

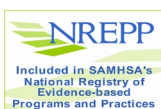
**DATE of Referral:** \_\_\_\_\_

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*

(Page 3 of 3)





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 \_\_\_\_\_

