



Program Director, 1-to-1
Mentoring and Compeer
Youth: Allisyn Wolfe

44 South Beaver Street
New Castle PA 16101

Phone: 724-654-5507

Fax: 724-654-5546

Email:
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Dear Referring Provider,

Thank you for your interest in referring your client to Compeer Lawrence County! Attached you will find our referral packet, Criteria for Acceptance, and a list of responsibilities you must agree to as the referral source.

Please review each of these documents before submitting the referral to ensure your client is eligible and appropriate for the program. We ask that you attach a psycho-social assessment of the client if you have one.

It is difficult to predict how long it will take to find an appropriate volunteer for your client — matches are made based on several factors such as age, personality traits, interests, level of client need versus the level of experience of the volunteer, and geographical location.

Cray Youth and Family Services has operated our County's only community based 1:1 Mentoring Program since 1996, and we are excited to expand our services to children and families who have a mental health diagnosis. We utilize community volunteers in a person-centered approach to combat the stigma and other challenges facing our youth and their families. We view our program as an adjunct to therapy and other services. It cannot operate alone, so we look forward to partnering with you to meet the goals of your client.

Sincerely,

Allisyn Wolfe
Program Director
1-to-1 Mentoring and
Compeer Youth



Compeer Lawrence County
44 South Beaver Street
New Castle PA 16101
724-654-5507

**RESPONSIBILITIES
OF REFERRAL SOURCE /
MENTAL HEALTH PROFESSIONAL**

As the referring Mental Health Professional, you must have contact with our staff to help determine the best match for youth you refer. Our Consent for Release of Information allows this contact and ongoing until Compeer services end.

You must be available to Compeer staff for issues of concern throughout the match.

You may be asked to facilitate meetings and/or other forms of communication between youth you refer, their parents or guardians, volunteers, and/or Compeer staff before and during the match.

You must notify Compeer of any changes in a youth's mental health (including diagnosis and hospitalizations), agency/mental health provider, school, or contact information.

Please let us know if the child / youth you refer is discharged from your care. This applies to youth waiting for a volunteer and youth who are matched. We will not present a youth to potential volunteers unless he or she is receiving an appropriate level of mental health treatment. If you close out a youth while he or she is still matched, Compeer staff will determine eligibility of youth to continue in the program.

If you make a referral but do not intend to be the primary contact for us, you must verify the primary contact person is full aware of and supportive of the referral, has a copy of this document, and can agree to the responsibilities listed above.

I have read, understand, and agree to the above responsibilities as the referring mental health professional:

Signature

Date

PLEASE ATTACH THIS SIGNED DOCUMENT TO ANY REFERRAL YOU SUBMIT

Criteria for Acceptance: Compeer
Lawrence County

Please complete this checklist prior to completing referral:

- | | | |
|---|-----|----|
| 1. Is client between the ages of 6 and 18? | Yes | No |
| 2. Does client reside in Lawrence County? | Yes | No |
| 3. Is client experiencing any condition putting him or her at risk for maladaptive behaviors? | Yes | No |
| 4. Is client interested in socializing and spending time out in the community with a volunteer? | Yes | No |
| 5. Is client's parent or guardian aware that referral is being made and supportive of referral? | Yes | No |
| 6. If referral is being made by a school-based Mental Health Professional, is there an alternative contact available during school break aside from the parent or caretaker (ex: outside therapist), or is referral source available by e-mail? | Yes | No |

If all above questions are answered "Yes," please proceed:

- | | | |
|--|-----|----|
| 7. Has client ever been convicted of a sexual or violent offense? | Yes | No |
| 8. Is client acutely suicidal? | Yes | No |
| 9. Is client diagnosed with a Substance Use Disorder? | Yes | No |
| 10. Has client been hospitalized in the past six months for a mental health concern? | Yes | No |
| 11. Is client active in other community mentoring programs? | Yes | No |
| 12. Has client been assigned more than two previous Compeer Volunteers in the past? | Yes | No |

If any of the above questions are answered "Yes," please contact us prior to making referral. If all of the above questions are answered no, please proceed with referral and be sure to answer the questions below prior to submitting referral:

- | | | |
|--|-----|----|
| 13. Is the referral completed in its entirety? | Yes | No |
| 14. Is all information relating to client's mental health history disclosed in the referral, including any history of behaviors that would be of concern to a volunteer's safety (ex. aggressive or violent behavior, chemical dependency, stealing, , and recent hospitalizations)? | Yes | No |
| | Yes | No |
| 15. If available, is a current psychosocial assessment attached? | | |

Information provided in the referral and supporting documents will be reviewed by Compeer Staff, and a decision will be made in the best interest of your client and our volunteers. All cases are reviewed on an individual basis. Compeer Lawrence County, a program of Cray Youth and Family Services, does not discriminate based on race, color, religion, disability, age, sex, gender identity, or sexual orientation.

- Information for this section may be gathered through client / family self-report or through review of documentation provided by the family or other mental health providers. If a psychological evaluation or Psycho-social evaluation is attached and contains the information, you do not need to fill out any of the sections that are addressed in the attached documentation.

DSM DIAGNOSIS — PROVIDE NAME AND CODE	
Primary:	Environmental Stressors:
Secondary:	
Medical Conditions:	Seriously Emotionally Disturbed? OYes ONo (severe functional impairment or symptoms of psychosis, and multiple risk-factors)
<i>Additional information: (optional)</i>	

PLEASE DESCRIBE YOUTH’S INTERACTION SKILLS IN EACH SETTING

Group:	1:1:
Structured:	Unstructured:
Ability to adhere to limits:	Ability to tolerate frustration:
How does youth interact with those with authority (i.e. parent, physicians, mental health professionals)?	
How does youth interact with peers?	
How does youth interact with those of different ages?	

PLEASE PROVIDE ADDITIONAL INFORMATION

What school does the child attend?	Grade Level:	School ID#:
General Personality Traits:		
Symptomatic Behaviors:		
Does youth have a history of physically aggressive behavior? <input type="radio"/> Yes <input type="radio"/> No Please describe:		
Has youth ever been charged with or convicted of a crime? <input type="radio"/> Yes <input type="radio"/> No If yes: What was the nature of the offense(s)? Location and Month/Year		
Does youth have any other medical conditions? <input type="radio"/> Yes <input type="radio"/> No Please describe:		
Does youth have any physical limitations? <input type="radio"/> Yes <input type="radio"/> No Please describe:		
Medication(s)/side effects a volunteer should be aware of:		
Does youth or youth's parent have a history of illicit drug use? <input type="radio"/> Yes <input type="radio"/> No Please describe:		
Are either parent(s) incarcerated? <input type="radio"/> Yes <input type="radio"/> No If yes, which facility?		

Has there been a Child Protective Services case opened with this family in the last year? <input type="radio"/> Yes <input type="radio"/> No Please describe:
Does youth participate in other programs (after-school, faith-based, vocational training/part-time job/volunteer work, recreational)? <input type="radio"/> Yes <input type="radio"/> No Please list:
Is it important that the volunteer be a specific age, gender, religion, ethnic background, or have a specific quality? <input type="radio"/> Yes <input type="radio"/> No Please specify:

GOALS FOR COMPEER RELATIONSHIP/WELLNESS

Prevention:
Emotional:
Social:
Physical Activity/Nutrition:

REFERRAL SOURCE INFORMATION:

Name:		Title:	
Agency:			
Address:		City:	State: Zip:
Phone:	Fax:	Email:	
Ok to text?	Relationship/role with youth:		Type of treatment (individual, family, group, medication):
Best time to call:	Relationship/role with youth:		Type of treatment (individual, family, group, medication):
Frequency of contact with youth:		Primary contact for Compeer Program? OYes ONo Ifno, complete box below	

Primary Mental Health Professional Contact:		Title:	
Agency:			
Address:		City:	State: Zip:
Phone:	Fax:	Email:	
Best time to call:	Relationship/role with youth:		Type of treatment (individual, family, group, medication):
Frequency of contact with youth:			

Waiver of Liability

Compeer programming involves a variety of activities. The level of participation in mentoring, events, or programs are at all times voluntary. Compeer staff members are committed to the safety of every participant, using several levels of volunteer screening and background checks, as well as choosing appropriate activities in the community. However, participants may be at risk for injury or other harm. This waiver must be completed and signed prior to enrollment.

I, _____ give permission for my child/youth, _____
Parent's Name Youth's Name

to participate in all Compeer activities unless otherwise stated below:

Please list any medications not already mentioned in referral:

Physician's Name _____ Office Phone _____

Office address: _____

Preferred Hospital: _____

Insurance Company: _____ Policy # _____

WAIVER; I realize that I must provide proper medical insurance, including hospitalization. I understand that participating organizations do not provide accident insurance coverage. I further understand that my child/youth is participating at his/her own risk and assume the risk of injury. I am aware that the activities in which my child/youth plans to participate could involve certain personal risks. I, therefore, release all rights or claims for damages against Compeer Lawrence County and Cray Youth and Family Services, and all individuals assisting and conducting these activities for any injuries suffered by my child/youth in connection with this activity.

Parent/Legal Guardian _____ Date _____

RESPONSIBILITIES OF COMPEER PROGRAM

- We will recruit, interview, screen, and provide training to volunteers before they are matched and give ongoing support and training during the match.
- We will monitor the volunteer and youth relationship via phone/e-mail and monthly update forms, and will advise you of any concerns that may arise. We will mail, fax, or email you a copy of the volunteer's monthly update form if it contains relevant information.
- We will get to know youth and their families via Parent Orientation, the Youth Self-Report, periodic Compeer-sponsored events, and checking in at least once every three months by phone. After a child is matched with a volunteer, we will contact the child, volunteer, and parent/guardian by phone or in person monthly throughout the first year of the match. We may remove a child or youth from our services if contact is not returned by the parent/caretaker or the Mental Health Provider.

