***Must be completed by a licensed mental health provider, physician, or other licensed health provider.***

**To be completed by Admissions Services Staff:**

Applicant Name:

List the mental health condition(s) disclosed by the applicant on form *ETA 6-53* *Job Corps Health Questionnaire:*

**To be completed by Applicant’s Licensed Health Provider:**

Your patient has applied to Job Corps and has disclosed the mental health condition(s) listed above. A copy of your patient’s authorization to release the requested information to Job Corps is enclosed.

The following information is requested to assist Job Corps Health and Wellness staff in determining the applicant’s health care needs and ability to safely participate in the Job Corps program. All information will be handled in the strictest confidence and forwarded to the appropriate licensed Health and Wellness staff for review.

1. **When was the last appointment?**
2. **Current diagnoses and status (*complete information below*):**

|  |
| --- |
| **Diagnosis 1:**  |
| Date of diagnosis:        |
| Current symptoms:       |
| Symptom severity:[ ]  Mild: Symptoms are manageable[ ]  Moderate: Symptom number and intensity and functional impairment between mild and severe[ ]  Severe: Intense symptoms with marked interference in social and occupational functioning[ ]  Other specifiers  |
| Restrictions/limitations: [ ]  None If any specify:        |
| Prognosis with treatment/medication: [ ]  Good [ ]  Fair [ ]  Poor [ ]  Guarded |
| Prognosis without treatment/medication: [ ]  Good [ ]  Fair [ ]  Poor [ ]  Guarded |
| **Diagnosis 2:**  |
| Date of diagnosis:       |
| Current symptoms:       |
| Symptom severity: [ ]  Mild: Symptoms are manageable[ ]  Moderate: Symptom number and intensity and functional impairment between mild and severe[ ]  Severe: Intense symptoms with marked interference in social and occupational functioning[ ]  Other specifiers        |
| Restrictions/limitations: [ ]  None If any specify:  |
| Prognosis with treatment/medication: [ ]  Good [ ]  Fair [ ]  Poor [ ]  Guarded |
| Prognosis without treatment/medication: [ ]  Good [ ]  Fair [ ]  Poor [ ]  Guarded |
| **Diagnosis 3:**  |
| Date of diagnosis:       |
| Current symptoms:       |
| Symptom severity:[ ]  Mild: Symptoms are manageable[ ]  Moderate: Symptom number and intensity and functional impairment between mild and severe[ ]  Severe: Intense symptoms with marked interference in social and occupational functioning[ ]  Other specifiers        |
| Restrictions/limitations: [ ]  None If any specify:       |
| Prognosis with treatment/medication: [ ]  Good [ ]  Fair [ ]  Poor [ ]  Guarded |
| Prognosis without treatment/medication: [ ]  Good [ ]  Fair [ ]  Poor [ ]  Guarded |

1. **Identify any high-risk behaviors in the past 12 months:** [ ]  None

|  |  |
| --- | --- |
| [ ]  Non-suicidal self-injury behaviors | [ ]  Physical aggression/violence towards others |
| [ ]  Suicidal Ideation (new onset)  | [ ]  Physical violence resulting in property damage |
| [ ]  Suicidal Ideation (chronic or intermittent) | [ ]  Homicidal ideation |
| [ ]  Suicide attempt(s) | [ ]  Other: |

1. **List past hospitalizations, including dates and reason for admission:** [ ]  None

|  |  |  |
| --- | --- | --- |
| **Hospital/Behavioral Health Facility Name** | **Dates** | **Reason for Admission** |
|       |       |       |
|       |       |       |
|       |       |       |

1. **Current psychotropic medications:** [ ]  None

|  |  |  |
| --- | --- | --- |
| **Medication, Dose and Frequency** | **Indication** | **Is patient adherent?** |
|       |       | [ ]  Yes[ ]  No |
|       |       | [ ]  Yes[ ]  No |
|       |       | [ ]  Yes[ ]  No |

1. **Is the applicant able to self-manage their medications with minimal supervision?** [ ]  Yes[ ]  No
2. **List the applicant’s other treatments including frequency and adherence:** [ ]  None
If any, specify:

1. **Follow-up Treatment Needs:**

Will the applicant need follow-up care? [ ]  Yes[ ]  No

* Continue follow up under your care? [ ]  Yes[ ]  No
	+ If YES, how often? Next appointment:
* Are you able to provide services to the applicant via telehealth? [ ]  Yes[ ]  No
* Follow up with another provider (PCP, psychiatrist, therapist—*circle as needed*)[ ]  Yes[ ]  No
	+ If YES, what type of service and recommended frequency

1. **Does the applicant currently require any of the following services?**
(***Note:*** *These are NOT services provided on center by Job Corps.*)

|  |  |  |  |
| --- | --- | --- | --- |
| Long-term individual counseling | [ ]  Yes[ ]  No | Partial hospitalization program | [ ]  Yes[ ]  No |
| Intensive outpatient program | [ ]  Yes[ ]  No | Therapeutic residential program | [ ]  Yes[ ]  No |
| Day treatment program | [ ]  Yes[ ]  No | Substance abuse treatment | [ ]  Yes[ ]  No |
| Group therapy | [ ]  Yes[ ]  No | Other:  | [ ]  Yes[ ]  No |

1. **List any accommodations you think the applicant needs to participate in an educational and vocational training program**: [ ]  None

|  |
| --- |
| **PLEASE READ:** Job Corps is a residential career and academic training program where students at most centers live in non-mental health dormitory-style residences with considerable periods of unsupervised time after 3:30 pm and free weekends. Students are expected to have independent living skills and not demonstrate behaviors that can impede their learning and the learning of others. Minimal, short-term mental health services are available on center. **In your professional opinion, are the applicant’s symptoms and behaviors sufficiently well-managed and are expected to remain stable enough to participate in the Job Corps program with limited supervision after the training day and on weekends?** [ ]  Yes[ ]  NoPlease explain:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

###### Print Name and Title of Licensed Health Provider Signature

###### Phone Date

For any questions, please call:             Admissions Services Staff Phone

 Health and Wellness Staff, if applicable Phone