

## Example of an HCNA with IEP Information

**FORM FOR INDIVIDUALIZED HEALTH CARE NEEDS ASSESSMENT**

**Applicant's Name:** Jacob Ray Williams **Date of Review:** 3/15/2021

**Center Name:** Best Center Ever **ID #:** 898989

**Interview conducted by:**     Telephone     In person     Videoconference

In determining whether, in your professional judgment, the above named individual's health care needs are beyond what the Job Corps' health and wellness program can provide as defined as basic health care in Exhibit 6-4: Job Corps Basic Health Care Responsibilities consider the following and respond accordingly.

If you determine that the individual's health care needs are beyond Job Corps basic health care responsibilities and their condition rises to a level of a disability, consider whether any accommodations or modifications would remove the barrier to enrollment and list any suggested accommodations or modifications. Do not consider whether, in your view, a particular accommodation or modification is "reasonable." That determination must be made by the center director or his/her designees.

**1. What factors triggered review of the individual's file for a health care needs assessment?**

*[Please mark all that apply]*

- Within the past six months, two or more emergency room visits or one or more hospitalizations for medical, mental health, oral health, and/or substance abuse reasons.
- New diagnosis or recurrence of medical, mental health, extensive untreated oral health, and/or substance abuse condition that would require frequent medication adjustments, significant health resources and/or substantial change to the training day (e.g., daily dialysis; only able to attend Job Corps 3 hours per day; hourly medication or behavioral monitoring; daily assistance with activities of daily living; long-term weekly on-center therapy provided by the CMHC; complex full-mouth reconstruction/rehabilitation).
- Failure to follow previous treatment recommendations by licensed health providers that have adversely affected the applicant's health, behavior, and/or adaptive functioning, and now requires significant health care management. (Note: Some students are non-adherent and experience adverse consequences but may still benefit from enrollment. Examples might include substance abuse relapse, poor diabetic control, poor asthma control, etc.).
- Applicant has followed treatment recommendations by licensed health providers with no improvement in applicant's health, behavior, and/or adaptive functioning, which continue to place applicant in need of significant health care management.
- Applicant's condition or behavior has not been successfully managed in a similar academic, work, or group environment in the past year.
- Applicant is in treatment for a condition that is not in the scope of Job Corps Basic Health Care Responsibilities (e.g., orthodontic braces for malocclusion).

**2. What is the applicant's history and present functioning to support statement of health care needs?**

*(Include information from ETA 653, file review, Chronic Care Management Plan (CCMP) Provider Form, and interview with applicant.)*

**ETA 653:** **List item number and description** *[Brackets are AC notes from Comments section.]*

- 8p. Been afraid that others want to physically harm you [*"Applicant mentioned he gets physically punished and harmed on his body by his parents, he stated they hit him with bare hands or objects when he makes mistakes."*]
- 8q. Heard voices or seen things that other people did not hear or see [*"Applicant mentioned he randomly hears whispers and sees a black shadow in the corner of his eye or behind him".*]
- 9j. Speech problem [*"Speech disability (included in IEP)".*]
- 9s. Learning disabilities [*"Refer to IEP."*]

- 9ff. A mental health problem or concern [*“Applicant mentioned he feels sadness/depression sometimes that comes and goes. He also stated he feels anxiety at times. Applicant has not been diagnosed or seen by a doctor for anxiety or depression.”*]

### Applicant File Review Summary:

#### Somewhere County Unified School District - Individual Education Plan (IEP)

- **Demographics**
  - Date: 2/16/20, Grade 11th, age 17
  - Initial Placement Date: 04/10/08
  - Type: Annual Review, Change of Placement for Fall 2020, and Transition Planning
  - Course of Study for High School Completion: Certificate of Completion
- **Primary Disability:** Specific Learning Disability. Secondary Disability: Speech or Language Impairment.
- **Present Level of Academic Achievement and Functional Performance:**  
Areas of concern were identified in:
  - Communication Skills (Social thinking, Collaborative conversation): “Jacob demonstrates difficulty using this information [verbal information, facial expression, body language and context to determine a person’s feelings or intent] in order to respond appropriately when using expected facial expressions and emotion....He would benefit from continued work in this area he would benefit from working on participating in a collaborative conversation with his peers.”
  - Social/Emotional/Behavior (Transition Planning): “Jacob is learning to be responsible for personal hygiene; taking frequent showers and washing clothes on a regular basis.”
- **Special Education Services:**
  - Primary Services: 15 hours/week in Other School/Community Location
  - Related Services: Language and Speech Services: 6 hours/week in Other School/Community Location and 4 hours/week in Separate Classroom/Public School Site.
  - Transition Services: 12 hours/week in Separate Classroom/Public School Site and 31 hours/week in Other School/Community Location
- **Percentage placements:** Special Education: 23%, General Education 77% from 8/30/20; Special Education 0%, General Education 100% 8/31/20 to 2/4/21. The drop in the special education percentage is due to the change of placement to TRACE program.
  - Rationale: “Jacob requires supports with functional skill-building sessions and navigating the community around him. He requires direct instruction in a small group setting, with a modified curriculum in order to reach educational, employment, and other transitional goals.”
- **Least Restrictive Environment:** “Having an additional adult in the classroom may disrupt classroom instruction, call attention to the student, or interfere with peer interaction. Students requires direct instruction in a small group setting, with a modified curriculum in order to reach educational, employment and other transitional goals.”
- **Postsecondary Education/Training Needs:** “After 4 years in high school, Jacob will work towards his diploma at TRACE. Jacob will begin his Change of Placement (COP) at TRACE in the fall of 2020, after receiving a Certificate of Completion (COC) from AW Technical High School (Spring 2020).”
  - **NOTE:** According to their website, “TRACE is part of the district’s continuum of service options for assisting students transitioning from high school to adult life. The focus is to make students as independent as possible in their own community as driven by the Individualized Education Plan (IEP), the Transition Plan (TP), and the Person Centered Plan (PCP).”

**CCMP Provider Form:** Does provider recommend applicant to enter Job Corps?  Yes  No  
*If conflicting recommendation with treating provider, please indicate effort to contact treating provider for discussion in addition to summary of information on the CCMP.*

No CCMP was provided.

Leave checkboxes blank if no CCMP is included in the e-Folder.

**Applicant Interview Summary:**

- Applicant demonstrated an inability to fully participate in the interview, likely due to limited cognitive ability as well as psychosis. His thought content was concrete; his thought process was linear and goal-directed. His speech was normal in rate and volume, but was monotone and flat. His vocabulary was impoverished, and he was not able to elaborate on initial responses. There were several times when he hesitated to respond after a question or briefly stopped mid-sentence, possibly due to responding to internal stimuli. Throughout the interview, his emotionality seemed blunted. Questions and statements were shortened, simplified and repeated or rephrased as needed to facilitate comprehension.
- Applicant endorsed a wide range of mental health symptoms including anxiety, panic symptoms, and feeling suicidal in the last month. He endorsed auditory and visual hallucinations. He reported self-injurious behavior, namely “eating arm” until he “feels the pain vibrating inside me.” After stating this, he indicated that it sounded crazy, and he didn’t want to talk about it.
- He reported that he was hungry and not eating due to insufficient food for everyone in the house including a younger sister. He stated that food would be coming the next day but could not elaborate on how or who would bring the food. The CMHC verbally provided and emailed mental health and food assistance resources. He reported that he already had the local Access and Crisis Line (211) but stated that he would not be able to get food from a food bank because he didn’t know how to get to one.
- Applicant endorsed each of the functional limitations checked below. The most significant ones based on frequency or rating by the applicant on a scale of 1 to 10 (10 = worst) were:
  - Trouble getting along with others (daily, 6)
  - Have a hard time being in large groups of people or in social situations (weekly, 7)
  - Have hard time handling stress (daily, 5). Applicant reported “cleaning” as a coping strategy.
  - Have a hard time managing feelings or moods (depression, daily, 10)
  - Have a hard time expressing what you want to say in words (a lot, 10)
  - Have panic attacks (hyperventilates when “something doesn’t go as planned,” 10)
  - Need help taking care of yourself (daily, 7, needs assistance getting up every morning, does not know how to do laundry)

If you use the Sample Applicant Interview Questions (recommended), consider summarizing Question #13 about functional limitations using bullets like this.

**What are the functional limitations (specific symptoms/behaviors) of the applicant that are barriers to enrollment at this time?**

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Avoidance of group situations and settings | <input checked="" type="checkbox"/> Difficulty with self-care   |
| <input type="checkbox"/> Impaired decision making/problem solving              | <input type="checkbox"/> Difficulty with sleep patterns   |
| <input checked="" type="checkbox"/> Difficulty coping with panic attacks       | <input checked="" type="checkbox"/> Difficulty with social behavior, including impairment in social cues and judgment |
| <input checked="" type="checkbox"/> Difficulty managing stress                 | <input type="checkbox"/> Difficulty with stamina  |
| <input checked="" type="checkbox"/> Difficulty regulating emotions             | <input type="checkbox"/> Interpersonal difficulties with authority figures and/or peers                               |
| <input checked="" type="checkbox"/> Difficulty with communication              | <input type="checkbox"/> Organizational difficulties  |
| <input type="checkbox"/> Difficulty with concentration                         | <input type="checkbox"/> Sensory impairments  |

- Difficulty handling change
- Difficulty with memory
- Uncontrolled symptoms/behaviors that interfere with functioning
- Other (specify) \_\_\_\_\_

Please note: This list is not all inclusive. These are suggestions for your use and you may need to consider functional limitations and accommodations beyond this list.

**4. What are the health-care management needs of the applicant that are barriers to enrollment at this time?**

- Complex behavior management system beyond Job Corps current system
- Complex full mouth reconstruction/rehabilitation
- Daily assistance with activities of daily living
- Frequency and length of treatment
- Hourly monitoring required
- Medical needs requiring specialized treatment
- Out of state insurance impacting access to required and necessary health care
- Severe medication side effects
- Therapeutic milieu required
- Other (specify) \_\_\_\_\_

Summarize symptoms/functional limitations and treatments/services needed.

**Brief Narrative:** The applicant endorsed a number of significant mental health symptoms including anxiety, panic attacks as well as difficulties with getting along with others, being around a lot of people, managing stress and regulating emotions. He reported self-injurious behavior (eating his arm) to manage emotional pain. The applicant will require at least weekly psychotherapy to develop coping skills to manage his symptoms. A psychiatric evaluation for possible pharmacotherapy is recommended. Finally, the applicant reported needing assistance with activities of daily living and his communication skills were deficient. Thus, he will require some assistance with some activities of daily living.

**5. Reasonable Accommodation Consideration**

Is this applicant a person with a disability?  Yes  No  
*(i.e., documentation of a mental health, medical, substance-abuse, cognitive, or other type of disability is present in the applicant file or the disability is obvious (i.e., blind, deaf). If no, please skip to Question #6.*

If yes, convene the reasonable accommodation committee (RAC) along with the applicant and list below any accommodations and/ or modifications discussed with the applicant that could either remove or reduce the barriers to enrollment as documented in Question #4 above.

Note: Accommodations or modifications are not things that treat the impairment; they are things that will help the individual participate in the program. See Program Instruction 08-26 “Reasonable Accommodation and Case Management” for guidance.

Check one of the two options below.

- The RAC has been unable to identify any accommodations appropriate to support this applicant.
- The following accommodations/modifications listed below have been discussed with the applicant and considered as a part of this assessment:

*Please avoid suggesting extreme accommodations already known to likely be unreasonable unless the applicant has requested a specific support (i.e., 24 hour supervision). If unsure if a support or modification is an accommodation or is actually a case management support, please contact your regional health and consultants for assistance.*

**Accommodation Checkboxes**  
 Yes = offered and accepted  
 No = offered but not accepted  
 Blank = not offered

<b>Based on functional limitation(s) checked in Section 3, please check the appropriate accommodations below discussed with the applicant. Please note: This list is not all inclusive. These are suggestions for your use and you may need to consider functional limitations and accommodations beyond this list which can be entered in the "Other" section.</b>		
<b>Avoidance of group situations and settings</b>		
Allow student to arrive 5 minutes late for classes and leave 5 minutes early	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Excuse student from student assemblies and group activities	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Identify quiet area for student to eat meals in or near cafeteria	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty coping with panic attacks</b>		
Allow student to designate a place to go when anxiety increases in order to practice relaxation techniques or contact supportive person	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Provide flexible schedule to attend counseling and/or anxiety reduction group	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Allow student to select most comfortable area for them to work within the classroom trade site	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide peer mentor to shore up support	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty handling change</b>		
Provide regular meeting with counselor to discuss upcoming changes and coping	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Maintain open communication between student and new and old counselors and teachers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recognize change in environment/staff may be difficult and provide additional support	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty managing stress</b>		
Allow breaks as needed to practice stress reduction techniques	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Modify education/work schedule as needed	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Identify support person on center and allow student to reach out to person as needed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty regulating emotions</b>		
Allow breaks as needed to cool down	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Allow flexible schedule to attend counseling and/or emotion regulation support group	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Teach staff to support student in using emotion regulation strategies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide peer mentor/support staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty with communication</b>		
Allow student alternative form of communication (e.g. written in lieu of verbal)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Provide advance notice if student must present to group and opportunity to practice or alternative option (e.g. present to teacher only)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty with concentration</b>		
Allow use of noise canceling headset	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reduce distractions in learning/work environment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide student with space enclosure (cubicle walls)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty with memory</b>		
Provide written instructions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allow additional training time for new tasks and hands-on learning opportunities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Offer training refreshers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use flow-charts to indicate steps to complete task	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide verbal or pictorial cues	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty with organization</b>		
Use staff/peer coach to teach/reinforce organizational skills	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Use weekly chart to identify and prioritize daily tasks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty with self-care</b>		
Provide environmental cues to prompt self-care	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Assign staff/peer mentor to provide support	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allow flexible scheduling to attend counseling/supportive appointments	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty with sleep patterns</b>		
Allow for a flexible start time	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide more frequent breaks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide peer/dorm coach to assist with sleep routine/hygiene	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Increase natural lighting/full spectrum light	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty with social behavior, including impairment in social cues and judgment</b>		
Assign mentor to reinforce appropriate social skills	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Allow daily pass to identified area to cool down	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Provide concrete examples of accepted behaviors and teach staff to intervene early to shape positive behaviors	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Adjust communication methods to meet students' needs	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty with stamina</b>		
Allow more frequent or longer breaks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allow flexible scheduling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide additional time to learn new skills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Impaired decision making/problem solving</b>		
Utilize peer staff mentor to assist with problem solving/decision making	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide picture diagrams of problem solving techniques (e.g., flow charts, social stories)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Interpersonal difficulties with authority figures and/or peers</b>		
Encourage student to take a break when angry	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide flexible schedule to attend counseling and/or therapy group	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide peer mentor for support and role modeling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Develop strategies to cope with problems before they arise	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provide clear, concrete descriptions of expectations and consequences	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allow student to designate staff member to check in with for support when overwhelmed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Sensory impairments</b>		
Modify learning/work environment to assist with sensitivities to sound, sight, and smells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allow student breaks as needed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Uncontrolled symptoms/behaviors that interfere with functioning</b>		
Alter training day to allow for treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allow passes for health and wellness center outside of open hours to monitor symptoms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reduce tasks and activities during CPP to not aggravate symptoms/behaviors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Other</b>		

<b>Summarize any special considerations and findings of the RAC as well as the applicant’s input:</b>

*Please Note: Job Corps cannot impose accommodations upon an individual. If the applicant does not accept or agree to a specific accommodation, there is no need to consider that specific accommodation in your determination of whether the accommodations listed will reduce the barriers to enrollment sufficiently or not nor is there a need to complete a reasonableness review related to that specific accommodation.*

<b>Reasonable Accommodation Considerations:</b>	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Did the applicant participate in the RAC meeting? ( <i>Note: The applicant must be a part of the discussion for reasonable accommodation</i> ).

<b>RAC Participants:</b>			
Name:	Daily Disability	Position:	Disability Coordinator
Name:	Patty Psychologist	Position:	CMHC
Name:	Jacob Williams	Position:	Applicant

If there is a recommendation for an applicant to be enrolled with the accommodations or modifications listed in Question #5 above which you believe are not reasonable and/or pose an undue hardship, the **Center Director is responsible for making that determination** using the “Accommodation Recommendation of Denial Form” found on the Job Corps Disability website and including that form along with the applicant file that is being submitted to the regional office with a recommendation for denial. The final determination is made by the regional office.

Guidance on how to make this determination is available in the “Evaluating a Request and Denying a Request” sections of the Appendix 605. Please attach the completed “Accommodation Recommendation of Denial Form.”

If there are agreed upon accommodations between the RAC and applicant listed in Question # 5 then consider whether those accommodations reduce the barriers to enrollment sufficiently to allow for the applicant to be enrolled.

- If the accommodations would sufficiently reduce the barriers to enrollment, then you do not need to complete the remainder of this assessment and the center can assign the applicant a start date. Retain all the paperwork included in completing this assessment within the applicant’s Student Health Record.
- If the accommodations would NOT sufficiently reduce the barriers to enrollment for your center, please proceed to Question #6.

**6. Based on your review of the applicant’s health care needs above, does the named individual have health care needs beyond what the Job Corps’ health and wellness program can provide as defined as basic health care in Exhibit 6-4: Job Corps Basic Health Care Responsibilities? [Please mark one below.]**

- In my professional judgment, health care needs are manageable at Job Corps as defined by basic health care services in Exhibit 6-4, but require community support services which are not available near center. Documentation of efforts to arrange for less frequent treatment in home state and/or to secure community support near center can be found in Question #7 below. Applicant should be considered for center closer to home where health support and insurance coverage is available. **File is forwarded to Regional Office for final determination.**
- In my professional judgment, health care needs are not manageable at Job Corps as defined by basic health care services in Exhibit 6-4. Applicant has health condition with current symptoms at a level that

will interfere with successful participation in the program at this time. Deny entry and refer to other appropriate program/provider. **File is forwarded to Regional Office for final determination.**

**7. If recommending a different center, document efforts to arrange less frequent treatment in home state and/or secure community support near center in the space below. (Include name of organizations/facilities and specific individuals contacted and why access is not available.)**

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Patty Psychologist

**Printed or Typed Name and Title of Licensed Health Provider Completing Form**

MUST BE SIGNED

**Signature of Licensed Health Provider Completing Form**

3/17/2021

**Date**