**Center Applicant/Student File Review Form**

*Health and Wellness Director’s Initial Review of Applicant Files or*

*Review of Student Documentation for Assignment of Possible Direct Threat Assessment*

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| **Applicant/Student:** |  | **ID #:** |  |
| **Center Name:** |  | **Date of Review:** |  |

**Center Applicant File Review and Student Documentation**

As part of the review of the applicant file, student health record, or interaction(s) with applicant/current student, please check all of the following that apply.

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|[ ]  1. The applicant has received conditional assignment to a Job Corps center and has completed the questions on the Job Corps Health Questionnaire (ETA 653).
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|[ ]  1. The applicant has responded “yes” to one or more questions in sections 8 and 9 of the ETA 653.
 |
|[ ]  1. Specific, objective, factual information about the applicant has been gathered that is medically related to “yes” responses in sections 8 and 9 of the ETA 653.
 |
|[ ]  1. The applicant or current student has voluntarily disclosed a medical condition or disability that may pose a significant risk of substantial harm to the health or safety of others.
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|[ ]  1. The initial review of this specific, objective, factual information by the Health and Wellness Director supports a reasonable belief that the applicant or current student may have a medical condition or disability that poses a significant risk of substantial harm to the health or safety of others, i.e., direct threat. If so, complete the section for ***Referral to Qualified Health Professional***.
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**Referral to Qualified Health Professional**

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| **Reason for Referral** | **Medical Professionals/Qualified Health Professionals** (List who needs to review.) |
|[ ]  Please review this applicant/student for assessment of a possible direct threat to others. |  |

**Comments**

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**Printed or Typed Name of Health and Wellness Director**

**Signature of Health and Wellness Director Date**

*Upload this form to the “Other” folder within the Wellness and Accommodation E-Folder (i.e., Health E-Folder) in CIS. A copy may be maintained within the Student Health Record (SHR) if enrolled.*

**FORM FOR INDIVIDUALIZED ASSESSMENT OF POSSIBLE DIRECT THREAT**

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| **Applicant/Student:** |  | **ID #:** |  |
| **Center Name:** |  | **Date of Review:** |  |

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| **Interview Conducted By:** |[ ]  Telephone |[ ]  In Person |[ ]  Videoconference |

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| **List/explain any reasonable accommodations, reasonable modifications in policies, practices, or procedures, or auxiliary aids or services (RA/RM/AAS) (effective communication supports) offered and/or provided during the applicant file review process (applicants), and/or completion of the direct threat assessment process (applicants/students). If not provided, please explain below.** See Form 2-03, Definitions and Documentation Requirements Related to Procedures for Providing RA/RM/AAS to Participate in the Job Corps Program. |
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In determining whether, in your professional judgment, the individual named above has a medical condition or disability that poses a direct threat to others, consider the following and respond accordingly.

Factors to be considered in determining whether a “significant risk of substantial harm” to the health or safety of others exists include: (1) duration of the risk, (2) nature and severity of the potential harm, (3) likelihood that the potential harm will occur, and (4) imminence of the potential harm.

Under the law, the burden is on Job Corps to prove that a specific individual poses a direct threat to others. Therefore, if the objective, factual information about the specific individual named above is equivocal (not clear), or is insufficient to *prove* that a direct threat exists, you must assume that the individual’s disability or medical condition does not pose a direct threat.

If you determine that a “significant risk of substantial harm” to others exists, consider whether any RA/RM/AAS could eliminate or reduce the risk sufficiently to allow for enrollment. Do not consider whether, in your view, a particular accommodation, modification in policies, practices, or procedures, and auxiliary aids and services is “reasonable.” That determination must be made by the Center Director or their designees.

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| **1**. | **What factors triggered review of the individual’s file for possible direct threat to others?** *(Include responses from ETA 6-53 (applicants only), information from applicant file/student health record, clinical interview and/or providers (applicants/students).)* |
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| **2.** | **What are the specific symptoms and behaviors related to the medical condition or disability considered to potentially pose a direct threat to others? (*Describe the specific symptoms and behaviors in detail.)*** |
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| **3**. | **What is the nature and severity of the potential harm to others (e.g., death, incapacitation, serious injury, minor injury/emotional distress)?** (*Include information from the applicant file/student health record, clinical interview and/or other providers.)* |
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| **4**. | **What is the duration of the risk (i.e., how long will the risk last)?** (*Include information from the applicant file/student health record, clinical interview, and/or other providers.)* |
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| **5**. | **What is the imminence of the potential harm (i.e., how soon is the harm likely to occur)?** (*Include information from the applicant file/student health record, clinical interview, and/or other providers.)* |
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| **6**. | **Based on the factors above, does the named individual have a medical condition or disability that poses a significant risk of substantial harm to the health or safety of others?** |
|[ ]  In my professional judgement, the individual’s medical condition or disability poses a significant risk of substantial harm to the health or safety of others.***If this box is checked, proceed to question #7 below.*** |
|[ ]  In my professional judgement, the individual’s medical condition or disability does not pose a significant risk of substantial harm to the health or safety of others, or it is not clear that the individual’s medical condition or disability poses a significant risk of substantial harm to the health or safety of others. *If this box is checked, then you* ***do not*** *need to complete the remainder of this assessment, and the center will assign the applicant a start date or the student will continue enrollment.* *Retain all the paperwork included in completing this assessment, including all documentation that was reviewed, and upload to the Wellness and Accommodation E-Folders. A copy may be maintained within the applicant’s or student’s health record.* |

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| **7**. | **Consideration of Reasonable Accommodations; Reasonable Modifications in Policies, Practices, and Procedures; and Auxiliary Aids and Services**  |
| Is the applicant or student a person with a disability (a physical or mental impairment that substantially limits one or more of their major life activities)?***If no, skip to #8. If yes, then continue to Post–Direct Threat Assessment Reasonable Accommodation, Reasonable Modification in Policies, Practices, or Procedures, or Auxiliary Aids and Services (RA/RM/AAS) Review.*** | Yes |[ ]  No |[ ]

**Post–Direct Threat Assessment Reasonable Accommodation, Reasonable Modification in Policies, Practices, or Procedures, or Auxiliary Aids and Services (RA/RM/AAS) Review**

*Qualified Health Professional Responsibilities*

If the individual has been determined to pose a direct threat to others and is a person with a disability, the qualified health professional, in collaboration with the Disability Coordinator, shall complete the process and information below to explore the available RA/RM/AAS possibilities to reduce or remove the direct threat to others. Ultimately, the qualified health professional is responsible for determining whether the available accommodations, modifications, or auxiliary aids and services would eliminate or sufficiently reduce the risk of harm to others.

*STEP 1*

*Qualified Health Professional Instructions*

**In the table below identify possible RA/RM/AAS and check the boxes to the left-hand side of the RA/RM/AAS table below. If there are other potential RA/RM/AAS that can reduce this applicant’s/student’s level of risk, insert in the OTHER section of each identified functional limitation.**

Here are some possible examples of RA/RM/AAS that could eliminate or reduce the risk. *Important: The items in the table are merely suggestions of RA/RM/AAS that may eliminate or reduce the significant risk of substantial harm to others in a given case. You should be flexible and creative in working with the applicant or student to consider any other potential options that would be effective to reduce or eliminate the harm.*

*STEP 2*

*Interactive Process Instructions*

Then, either the qualified health professional or the Disability Coordinator initiates an interactive process with the qualified individual with a disability to discuss the RA/RM/AAS that the qualified health professional checked (or suggested) in STEP 1 above (i.e., identifies the precise limitations resulting from the disability) and potential RA/RM/AAS that could overcome those limitations. The qualified health professional or the Disability Coordinator **documents whether the applicant/student accepts, declines, or there is agreement to modify the proposed RA or RM.**

**With respect to auxiliary aids and services (AAS), primary consideration must be given to the request of the applicant/student with a disability**. If the applicant/student or any other individual on the applicant’s/student’s behalf requests a RA/RM/AAS that potentially reduces the direct threat risk, the qualified health professional must consider these requests as well. If there is concern about the reasonableness of any related requested RA/RM/AAS, see Determining Reasonableness in Form 2-03.

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| **What changes can we make to our center policies, procedures, or practices to eliminate or reduce the level of risk?**  | **Accepts** | **Declines** |
|[ ]  Schedule adjustments to allow the student to attend necessary off-center appointments |[ ] [ ]
|[ ]  Shortened training day or later start to the training day to adjust for medication side effects |[ ] [ ]
|[ ]  Modified first 30 days on center with a reduction in tasks to minimize stress |[ ] [ ]
|[ ]  Provide a pass to leave class and go to designated “calm down” area  |[ ] [ ]
|[ ]  Allow frequent breaks during the day |[ ] [ ]
|[ ]  Allow telephone calls during work hours to doctors and others for needed support |[ ] [ ]
|[ ]  Reduce mandatory participation in large group activities |[ ] [ ]
|[ ]  Provide additional orientation on conduct and behavioral expectations |[ ] [ ]
| **OTHER ACCOMMODATIONS, MODIFICATIONS, OR AUXILIARY AIDS AND SERVICES** | **Accepts** | **Declines** |
|  |[ ] [ ]
|  |[ ] [ ]
|  |[ ] [ ]
| **What are the physical changes or placement considerations in the dorm we can make to eliminate or reduce the level of risk?**  | **Accepts** | **Declines** |
|[ ]  Provide single dorm room |[ ] [ ]
|[ ]  Modified door/window locks for safety |[ ] [ ]
|[ ]  Placement in residential dorm with fewer students and/or more experienced Residential Advisors (RAs)/Residential Counselors (RCs) |[ ] [ ]
|[ ]  Provide dorm room closer to RA’s/RC’s office |[ ] [ ]
|[ ]  Allow refrigerator in room |[ ] [ ]
| **OTHER ACCOMMODATIONS, MODIFICATIONS, OR AUXILIARY AIDS AND SERVICES** | **Accepts** | **Declines** |
|  |[ ] [ ]
|  |[ ] [ ]
|  |[ ] [ ]
| **What can we do to adjust our level of supervision or structure at the center to eliminate or reduce the level of risk?** | **Accepts** | **Declines** |
|[ ]  Provide staff mentor as needed (like a job coach) |[ ] [ ]
|[ ]  Provide student mentor as needed |[ ] [ ]
|[ ]  Provide additional or different auxiliary aids or services |[ ] [ ]
| **OTHER ACCOMMODATIONS, MODIFICATIONS, OR AUXILIARY AIDS AND SERVICES** | **Accepts** | **Declines** |
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| **How can our instructors and/or RA/RC staff adjust their communication methods in a way to eliminate or reduce the level of risk?** | **Accepts** | **Declines** |
|[ ]  Provide detailed guidance |[ ] [ ]
|[ ]  Provide frequent feedback |[ ] [ ]
|[ ]  Provide praise and positive reinforcement |[ ] [ ]
| **OTHER ACCOMMODATIONS, MODIFICATIONS, OR AUXILIARY AIDS AND SERVICES** | **Accepts** | **Declines** |
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| **What equipment, device, or auxiliary aids and services can we consider that can eliminate or reduce the level of risk?** | **Accepts** | **Declines** |
|[ ]  Provide visual barriers to reduce startle responses |[ ] [ ]
|[ ]  Use of headphones to minimize distractions |[ ] [ ]
| **OTHER EQUIPMENT, DEVICES, OR AUXILIARY AIDS AND SERVICES** | **Accepts** | **Declines** |
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| Complete this section if the qualified health professional, in collaboration with the Disability Coordinator, has been unable to identify any RA/RM/AAS appropriate to support this applicant/student to reduce or remove the direct threat. *Provide explanation/justification here. For example, the applicant has a current and/or extensive history of aggression and violence that is escalating in frequency and severity.* |
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| *Summarize any special considerations and findings as well as the applicant’s or student’s input related to* ***accommodations ONLY****. For example, if the applicant/student does not wish to discuss accommodations, document that information here.*  |
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***Please Note: Job Corps cannot impose RA/RM/AAS upon an individual.***

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| **8.** | **Clinical and Disability Accommodation Process (DAP) Summary.** |
| **a.** | **Clinical Summary: Summarize information from the file, clinical interview and/or discussions with providers to support the direct threat assessment.** |
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| **b.** | **Disability Accommodation Process (DAP) Summary: If RA/RM/AAS were identified above, include a detailed explanation for why these supports would not sufficiently reduce the risk to allow for enrollment or to remain in the Job Corps program.**  |
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| I attest that I have the necessary licensure, training, and clinical experience to complete this assessment, including experience conducting safety assessments and identifying treatment, intervention and care management needs related to the symptoms and behaviors of this applicant’s/student’s documented health conditions. **Printed or Typed Name and Title of Qualified Health Professional Conducting the Assessment****Signature of Qualified Health Professional Conducting the Assessment Date****Signature of Second Consulting Qualified Health Professional Date*****(if applicable)*** |