CHRONIC CARE MANAGEMENT PLAN

### GENERAL HEALTH QUESTIONNAIRE

**[To be completed by a licensed mental health provider, physician or other licensed health provider.]**

Please provide us with the following information related only to the medical, mental health, substance abuse, or oral health condition listed below which the applicant has disclosed:

The information provided will be used to assist Job Corps staff in determining the applicant’s health care needs and ability to successfully participate and benefit from the Job Corps program.

All information released will be handled in the strictest confidence and forwarded to the appropriate licensed health and wellness staff for evaluation and review. A copy of your patient’s authorization to release the requested information is enclosed.

1. Diagnosis:
2. Date of diagnosis: Age of onset:
3. What are the current symptoms related to the disclosed health condition?
4. List current medications and/or treatment including dosage and frequency, related to the disclosed health condition.

1. Has applicant been compliant with medications and treatment related to the disclosed health condition? If no, please explain and state prognosis without medication.
2. List past hospitalizations related to the disclosed health condition, including dates, reasons admitted, and discharge summaries, if available.
3. List current (within the past 6 months) self-harm behaviors related to the disclosed health condition, if applicable.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What is current status and prognosis?
5. When was last appointment?
6. Will the applicant need to continue follow up under your care? If yes, please list the date and/or frequency of follow up appointments.
7. In your opinion, will the applicant be able to self-manage medications unsupervised and participate in a vocational training program. If no, please explain.
8. In your opinion, will the applicant be appropriate to reside in a dormitory-style residence with minimal supervision? If no, please explain.
9. Are there any restrictions or limitations related to this specific illness?
10. List any environmental features, which might trigger worsening symptoms (e.g., noisy room, crowded room with strangers, family gatherings, etc.). \_
11. Does this applicant demonstrate any challenging behaviors related to the disclosed health condition? If yes, please describe

1. What accommodations, if any, do you believe are necessary for this applicant to participate in a vocational training program?

1. Are there any specific educational needs for this applicant that you feel need to be reinforced? Check all that apply.

\_\_\_\_\_\_ Dietary Instructions \_\_\_\_\_\_ Physical Activity \_\_\_\_\_\_ Medications

\_\_\_\_\_\_ Other:

**PLEASE READ:** Job Corps is a residential career and academic training program where students at most centers live in 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 be capable of self-management of their chronic illness. Centers have nursing staff present on weekdays and visits by a center physician are scheduled with frequency determined by the size of each center.

In your professional opinion, are the applicant’s symptoms sufficiently well-controlled 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☐ No   If No, please explain.

**Please sign below and return the form in the attached addressed envelope.**

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

###### Phone Date

For any questions, please call:

 Admission Counselor/Health and Wellness Staff Phone