

Applicant Name \_\_\_\_\_

(Last, First, Middle Initial)

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical Case Number: \_\_\_\_\_  
(Mo/Day/Year)

**Mental Health Current  
Evaluation Form**  
OMB No.: 0420-0550  
Expiration Date: 1/31/2014

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## **MENTAL HEALTH CURRENT EVALUATION FORM (CONFIDENTIAL)**

The individual listed above has applied to serve as a Peace Corps Volunteer and has reported a history of a mental health condition, mental health counseling, or use of medication for mental health. The mental health provider who has oversight and management of the applicant's treatment, or has access to the applicant's mental health records, should complete this mental health current evaluation form. If you do not have access to the appropriate records, please indicate this on the form.

**Note to the Provider:** Please be candid when answering the questions below. During Peace Corps service, a Volunteer may be placed in a community that is very isolated and remote and has a history of violence, high crime, extreme poverty, or inequitable treatment. There may be limited access to Western-trained mental health professionals and little support for existing or new mental health symptoms. **Please answer all questions or the form will be considered incomplete and returned to the applicant.**

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### **Privacy Act Notice**

This information is collected under the authority of the Peace Corps Act, 22 U.S.C. 2501 et seq. It will be used primarily for the purpose of determining your eligibility for Peace Corps service and, if you are invited to serve as a Peace Corps Volunteer, for the purpose of providing you with medical care during your Peace Corps service. Your disclosure of this information is voluntary; however, your failure to provide this information will result in the rejection of your application to become a Peace Corps Volunteer.

This information may be used for the purposes described in the Privacy Act, 5 USC 552a, including the routine uses listed in the Peace Corps' System of Records. Among other uses, this information may be used by those Peace Corps staff members who have a need for such information in the performance of their duties. It may also be disclosed to the Office of Workers' Compensation Programs in the Department of Labor in connection with claims under the Federal Employees' Compensation Act and, when necessary, to a physician, psychiatrist, clinical psychologist or other medical personnel treating you or involved in your treatment or care. A full list of routine uses for this information can be found on the Peace Corps website at <http://multimedia.peacecorps.gov/multimedia/pdf/policies/systemofrecords.pdf>.

### **Burden Statement:**

Public reporting burden for this collection of information is estimated to average 4 hours and 25 minutes per applicant and 3 hours per mental health professional per response. This estimate includes the time for reviewing instructions and completing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: FOIA Officer, Peace Corps, 1111 20th Street, NW, Washington, DC, 20526 ATTN: PRA (0420 - 0550). Do not return the completed form to this address.



Medical Case Number:

Mental Health Specialist: \_\_\_\_\_ Date: \_\_\_\_\_

Professional degree: \_\_\_\_\_ License No.: \_\_\_\_\_ State: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Dates of Evaluation Sessions:** (Note to the Provider: Please complete the dates of evaluation sessions, up to three separate visits, as you feel is necessary to evaluate the current mental health status. Three visits are not required if one or two sessions are sufficient time to complete an assessment)

a.) \_\_\_\_\_ b.) \_\_\_\_\_ c.) \_\_\_\_\_

**Prior to this evaluation, have you treated this applicant for a mental health condition?**

Yes  No

**Have you received mental health reports for this applicant?**  Yes  No

(Where applicable, please have the applicant include information about psychiatric hospitalizations.)

**Mental Health History**

**A. Diagnosis History: (DSM IV Codes)**

Diagnoses	Date Given
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	

**B. Presenting Symptoms: Please be as specific and comprehensive as possible.**

Symptom	Onset	Severity	Duration	Date remitted

**Current Mental Health Evaluation**

**A. Clinical Assessment, with focus on:**

1.) Ego strength, emotional stability, and flexibility: \_\_\_\_\_  
\_\_\_\_\_

2.) Risk of symptom recurrence in a stressful overseas environment (characterized by isolation, lack of structure, and limited social supports): \_\_\_\_\_  
\_\_\_\_\_

3.) Coping strategies: \_\_\_\_\_  
\_\_\_\_\_



**B. Assessment of Current Functioning:**

- 1.) Evaluation of overall functioning: \_\_\_\_\_  
\_\_\_\_\_
- 2.) Interpersonal relationships: \_\_\_\_\_  
\_\_\_\_\_
- 3.) Work/school functioning: \_\_\_\_\_  
\_\_\_\_\_

**C. Current Assessment: DSM IV (Please complete all five axes):**

Diagnoses	Date Given
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	

**D. Psychotropic Medications (*Current and Previous*):**

*Please have the prescribing mental health professional complete this portion.*

Medication and Dosage: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Response to Medication: \_\_\_\_\_

Recommended Monitoring Plan: \_\_\_\_\_

Medication and Dosage: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Response to Medication: \_\_\_\_\_

Recommended Monitoring Plan: \_\_\_\_\_

Medication and Dosage: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Response to Medication: \_\_\_\_\_

Recommended Monitoring Plan: \_\_\_\_\_

Signature and title if different from the person completing the rest of this form: \_\_\_\_\_

Name and title \_\_\_\_\_ Date \_\_\_\_\_



**E. Current Psychological Tests Administered** (*Please attach any pertinent reports or summaries, if any*):

- a. \_\_\_\_\_
- b. \_\_\_\_\_

**F. Clinical Observations:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**G. Recommendations and Follow up:** What specific recommendations for mental health support do you have regarding the management of this applicant's condition over the next three years? All recommendations will help determine the best placement for the Peace Corps Volunteer. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any concerns that would prevent this applicant from completing 27 months of service without undue disruption due to a mental health condition? NOTE: Peace Corps service may be in areas that are isolated or have limited access to Western-trained providers and health care systems. Please check one box below.

- I have no concerns. This applicant, with regard to mental health conditions, is healthy enough to complete 27 months of uninterrupted Peace Corps service provided these recommendations can be accommodated.
- I am unsure that this applicant can, due to a mental health condition, complete 27 months of uninterrupted Peace Corps service. I recommend a period of stabilization for this condition and an updated assessment at a future date. Please describe and include length of time for stabilization: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- I do not believe that this applicant can, due to a mental health condition, complete 27 months of Peace Corps service without disruption.

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I certify this information is, in my opinion, an accurate representation of the baseline status of this mental health condition for the applicant listed above.

Mental Health Professional Signature/Title \_\_\_\_\_

Mental Health Professional Name (Print) \_\_\_\_\_

Date \_\_\_\_\_

