Applicant Name_____
(Last, First, Middle Initial)

Date of Birth_____/_____/_____
(Mo/Day/Year)

Mental Health Current Evaluation and Treatment Summary Form
OMB No.: 0420-0550
Expiration Date: 00/00/0000

Mental Health Current Evaluation and Treatment Summary 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, and/or use of a medication related to a mental health condition. 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 form. If you do not have access to appropriate records, please indicate this on the form.

Note to the Mental Health 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, with the potential for a history of high crime, history of violence, current extreme poverty, and/or inequitable treatment of members of the population. There may also be limited access to Western-trained mental health professionals and little support for existing or new mental health symptoms. Please take these factors into consideration when answering the questions below. This form will also be considered "incomplete" and returned to the applicant if all questions are not answered.

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 service 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 or failure to disclose relevant information may 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 U.S.C. 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, licensed clinical social worker 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 105 minutes per applicant and 60 minutes per mental health provider 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 complete from to this address.

Mental Health Provider's Name & Degree (Print): _____

Date: _____ License No.: _____ State: _____

Address: _____ Phone: _____

If Providing a Current Evaluation - Dates of Evaluation Sessions

Note to the Provider: Please complete as many evaluation sessions (one, two, or three 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 of prior treatment for this applicant? ☐ Yes ☐ No
If marked "No" or documentation is insufficient, then please be sure to inquire fully about the applicant's mental health treatment history.

If Providing a Summary of Treatment - Dates and Frequency of Therapy Sessions

Date of First Session: _____ Frequency of Sessions: _____

Date of Most Recent Session: _____ Was this a Final Session: ☐ Yes ☐ No
If marked "Yes," was termination satisfactory and/or mutual? _____

Course of Treatment

Please identify the modality, treatment goals, applicant's reaction to treatment, and any other relevant clinical information.

_____

_____

_____

_____

_____

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_____

<u>All Providers:</u> Mental Health History (Updated for DSM-5)

Please provide the following information based on your treatment and/or clinical assessment of this applicant. Please be as detailed as possible.

A. Past & Current Clinical Disorders (Formerly Axes I, II, and III in DSM-IV-TR)

Please indicate date given and date remitted, if applicable. Please also indicate if no current diagnosis is present or if diagnosis is ongoing.

Mental Disorders:

Diagnosis	Date Given	Date Remitted	Ongoing
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

General Medical Disorders:

Diagnosis	Date Given	Date Remitted	Ongoing
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

B. Past & Current Mental Health Symptoms

Please be as specific and comprehensive as possible.

Symptom	Onset	Severity	Duration	Date Remitted

C. Past & Current Psychosocial/Contextual Factors (Formerly Axis IV in DSM-IV-TR)

Please identify any relevant concerns, past and current, related to the following: primary support group, social environment, housing/living situation concerns, education/work concerns, economic concerns, legal concerns, cultural/environmental concerns, and any other factors. Indicate beginning date and date remitted/ongoing, if applicable.

_____

_____

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D. Assessment of Functioning (Formerly Axis V in DSM-IV-TR)

Please identify any concern, past and current, regarding the follow areas: self-care, social functioning, and activities of daily living. Indicate date given and date remitted, if applicable.

_____

_____

_____

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_____

E. Past & Current Mental Health Hospitalizations & Treatment

Past Treatment? ☐ Yes ☐ No Date(s): _____ **From intake to discharge* If "Yes," please describe context/reasons. _____ _____ _____ _____	Current Treatment? ☐ Yes ☐ No Date: _____ **Intake* If "Yes," please describe context/reasons. _____ _____ _____ _____	Hospitalizations? ☐ Yes ☐ No Date(s): _____ **From intake to discharge* If "Yes," please describe context/reasons. _____ _____ _____ _____

F. Past & Current Risk Assessment & Information

Suicide Attempt? ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and outcome(s). _____ _____ _____ **Risk of Recurrence (Check One):** ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this	**Suicidal Gesture?** ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and outcome(s). _____ _____ _____ **Risk of Recurrence (Check One):** ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this	**Suicidal Ideation?** ☐ Yes ☐ No Date(s): _____ If "Yes," please describe context(s) and outcome(s). _____ _____ _____ **Risk of Recurrence (Check One):** ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this	**Self-Injurious Behaviors?** ☐ Yes ☐ No Date(s): _____ **From start to remittance* If "Yes," please describe context(s) and outcome(s). _____ _____ **Risk of Recurrence (Check One):** ☐ None/Unlikely ☐ Possible/Likely *Describe:* _____ _____ _____ ☐ I am unable to assess this

G. Psychotropic Medications (Current & Previous)

**** If possible, please have the prescribing clinician complete this section. ****

Medication and Dosage	Start Date	End Date	Response to Medication	Recommended Monitoring Plan

Signature: _____ Date: _____

Name & Title (Print): _____

H. Clinical Assessment

Psychological tests/measures administered:
(Please attach pertinent reports or summaries, if any)

1. _____

2. _____

To the best of your ability, describe the applicant's ego strength, emotional stability, and flexibility:

_____

_____

_____

_____

To the best of your ability, rate and describe the applicant's risk of symptom recurrence in a stressful overseas environment **(characterized by isolation, lack of structure, and limited social supports)**:

☐High/Likely ☐ Possible ☐ Low/Unlikely

_____

_____

_____

_____

To the best of your ability, describe the applicant's coping strategies:

_____

_____

_____

_____

To the best of your ability, describe the applicant's overall functioning and prognosis based on your clinical observations:

_____

_____

_____

_____

_____

_____

I. Recommendations & 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 applicant.

_____

_____

_____

_____

Any other comments or concerns related to the information provided on this form or regarding this applicant?

_____

_____

_____

_____

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 Provider's Signature: _____

Date: _____