Peace Corps

Mental Health Evaluation and Treatment Summary

Peace Corps must fully and accurately understand the current health of potential Volunteers and assess whether we can appropriately support and accommodate their individualized health care needs.

This individual has applied to serve as a Peace Corps Volunteer and has reported a history of a mental health condition, counseling, and/or use of a medication related to a mental health condition.

During Peace Corps service, a Volunteer may be placed in a community that is very isolated and remote with a history of high crime, violence, extreme poverty, and/or inequitable treatment of members of the population. There may 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 completing this form.

Provider Instructions:

- Please complete the form in its entirety and mark N/A if not applicable.
- If you have questions, please contact the Peace Corps Medical Office at 202-692-4047 or pre-serviceunit@peacecorps.gov.
- Return the form to the individual **or** by confidential fax to the Peace Corps Medical Office at 202-692-1561.

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 form to this address.

Applicant Name (Last, First): _____

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

_____

Date Form Completed: _____

This individual is:

Currently engaged in counseling/treatment:
☐ With me (the provider) or my practice
☐ With another provider

Or

Previously engaged in counseling/treatment:
☐ With me (the provider) or my practice
☐ With another provider

Have you received mental health reports of prior treatment for this individual? ☐ Yes ☐ No

If "No" or if documentation is insufficient, please inquire fully about the individual's mental health treatment history.

Date range of treatment: _____

Frequency of sessions: _____

Were there gaps in treatment? ☐ Yes ☐ No

If yes, explain: _____

Is treatment ongoing? ☐ Yes ☐ No

If no, date of termination: _____

Was termination satisfactory and/or mutual? ☐ Yes ☐ No

If no, explain: _____

Please identify treatment modality:

Treatment plan, individual's reaction to treatment, and other relevant clinical information:

Other current treatment not listed above, including dates:

A. Clinical Disorders

Mental Disorders and Conditions

Diagnoses (past and current) ***Ex: Generalized Anxiety Disorder, Major Depressive Disorder, etc.***	**Date Given**	**Date Remitted**	**Ongoing**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Mental Health Symptoms

Symptoms (past and current) ***Ex: depressed mood, panic attacks, etc.***	**Onset**	**Severity**	**Duration**	**Date Remitted**

Co-existing Medical Disorders:

Diagnoses ***Ex: insomnia, chest pain, thyroid disease, etc.***	**Date Given**	**Date Remitted**	**Ongoing**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

B. Psychosocial/Contextual Factors (past and current):

Please identify any relevant concerns, 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, or ongoing, if applicable.

C. Assessment of Functioning (past and current):

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

D. Mental Health Hospitalizations (residential, inpatient, partial, and intensive outpatient):

Has the individual ever received intensive treatment or hospitalization? ☐ Yes ☐ No

If yes, explain and provide date(s).

E. Risk Assessment & Related Information (past and current):

1) Has this individual ever attempted suicide? ☐ Yes ☐ No

If yes, explain and provide dates, contexts, and outcomes:

Risk of recurrence (check one): ☐None/Unlikely ☐Possible/Likely ☐Unable to assess

Describe:

2) Has this individual ever made a suicidal gesture? ☐ Yes ☐ No

If yes, explain and provide dates, contexts, and outcomes:

Risk of recurrence (check one): ☐None/Unlikely ☐Possible/Likely ☐Unable to assess

Describe:

3) Has this individual ever had suicidal ideation? ☐ Yes ☐ No

If yes, explain and provide dates, contexts, and outcomes:

Risk of recurrence (check one): ☐None/Unlikely ☐Possible/Likely ☐Unable to assess

Describe:

4) Has this individual ever engaged in self-injurious behaviors? ☐ Yes ☐ No

If yes, explain and provide dates, contexts, and outcomes:

Risk of recurrence (check one): ☐None/Unlikely ☐Possible/Likely ☐Unable to assess

Describe:

F. Treatment History:

Has the individual engaged in previous outpatient counseling/treatment? ☐ Yes ☐ No

If yes, explain and provide date(s).

G. Psychotropic Medications (past and current):

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

H. Clinical Assessment

Psychological tests/measures administered with scores:

1) _____

2) _____

To the best of your ability, describe the individual's:

a) Emotional stability, flexibility and overall functioning

b) Coping strategies given the resource-limited environment available to Peace Corps Volunteers

c) Risk of symptom recurrence in a stressful overseas environment (characterized by isolation, lack of structure, and limited social supports): ☐High/Likely ☐ Possible ☐ Low/Unlikely

I. Recommendations & Follow Up

1) What specific recommendations for mental health support do you have regarding the management of this individual's condition over the next three years? All recommendations will help determine the best placement for the Peace Corps applicant.

2) Do you have any other comments or concerns related to the information provided on this form or regarding this individual?

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

Mental Health Provider's Signature: _____

License No.: _____ State: _____

Practice Address: _____