Supplemental Form to

# Questionnaire for Designated Law Enforcement/Sensitive Positions

| Questionnaire Continuation | | | | |
|---|---|---|---|---|
| Last Name | First Name | Middle Name | Jr., II, etc. | Last 4 - Social Security Number |
| | | | | |

## Psychological and Emotional Health

[ ] recognizes the critical importance of mental health and advocates proactive management of mental health conditions to support the wellness and recovery of employees and others. Every day individuals with mental health conditions carry out their duties without presenting a security risk. While most individuals with mental health conditions do not present security risks, there may be times when such a condition can affect a person's eligibility for a law enforcement position.

Individuals experience a range of reactions to traumatic events. For example, the death of a loved one, divorce, major injury, service in a military combat environment, sexual assault, domestic violence, or other difficult work-related, family, personal, or medical issues may lead to grief, depression, or other responses. [ ] recognizes that mental health counseling and treatment may provide important support for those who have experienced traumatic events, as well as for those with other mental health conditions. Nothing in this questionnaire is intended to discourage those who might benefit from treatment or from seeking it.

Mental health treatment and counseling, in and of itself, is not a reason to revoke or deny eligibility for a law enforcement position, or fitness to obtain or retain employment. Seeking or receiving mental health care for personal wellness and recovery may contribute favorably to a decision about your eligibility.

Has a court or administrative agency EVER issued an order declaring you mentally incompetent? ☐ Yes ☐ No (If NO, proceed to next question)

Complete the following if you answered "Yes" to having court or administrative agency EVER issuing an order declaring you mentally incompetent.

| #1 Provide the date this occurred. (Month/Year) ☐ Est. | Provide the name of the court or administrative agency that declared you mentally incompetent. |
|---|---|

Provide the address of the court or administrative agency.

| Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

Was this matter appealed to a higher court or administrative agency? ☐ Yes ☐ No

Appeal #1

| Provide the name of the court or administrative agency. | Provide the final disposition. |
|---|---|

Provide the address of the court or administrative agency.

| Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

Appeal #2

| Provide the name of the court or administrative agency. | Provide the final disposition. |
|---|---|

Provide the address of the court or administrative agency.

| Street | City | State | Zip Code |
|---|---|---|---|
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| Questionnaire Continuation | | | | |
|---|---|---|---|---|
| Last Name | First Name | Middle Name | Jr., II, etc. | Last 4 - Social Security Number |
| | | | | |

## Psychological and Emotional Health

Has a court administrative agency EVER ordered you to consult with a mental health professional (for example, a psychiatrist psychologist, licensed clinical social worker, etc.)? (An order to a military member by a superior officer is not within the scope of this question, and therefore would not require an affirmative response. An order by a military court would be within the scope of the question and would require an affirmative response.) ☐ Yes ☐ No (If NO, proceed to next question)

Complete the following if you answered "Yes" to having a court administrative agency EVER ordered you to consult with a mental health professional.

| #1 Provide the date this occurred. (Month/Year) ☐ Est. | Provide the name of the court or administrative agency that ordered you to consult with a mental health professional. |
|---|---|

Provide the address of the court or administrative agency.

| Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

Provide the final disposition.

Was the matter appealed to a high court or administrative agency? ☐ Yes ☐ No

Appeal #1

| Provide the name of the court or administrative agency. | Provide the final disposition. |
|---|---|

Provide the address of the court or administrative agency.

| Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

Appeal #2

| Provide the name of the court or administrative agency. | Provide the final disposition. |
|---|---|

Provide the address of the court or administrative agency.

| Street | City | State | Zip Code |
|---|---|---|---|
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| Questionnaire Continuation | | | | |
|---|---|---|---|---|
| Last Name | First Name | Middle Name | Jr., II, etc. | Last 4 - Social Security Number |
| | | | | |

## Psychological and Emotional Health

Have you EVER been hospitalized for a mental health condition? ☐ Yes ☐ No (If NO, proceed to next question)

| Complete the following if you answered "Yes" to having been hospitalized for a mental health condition | | | |
|---|---|---|---|
| #1 Was the admission voluntary or involuntary? | Provide the dates of treatment. | | |
| ☐ Voluntary Explanation:<br>☐ Involuntary Explanation: | From date (Month/Year) ☐ Est. | To Date (Month/Year) ☐ Est. | |
| Provide the name of the facility where treatment was provided. | | | |
| Provide the address of the court or administrative agency. | | | |
| Street | City | State | Zip Code |
| | | | |

| Complete the following if you answered "Yes" to having been hospitalized for a mental health condition | | | |
|---|---|---|---|
| #2 Was the admission voluntary or involuntary? | Provide the dates of treatment. | | |
| ☐ Voluntary Explanation:<br>☐ Involuntary Explanation: | From date (Month/Year) ☐ Est. | To Date (Month/Year) ☐ Est. | |
| Provide the name of the facility where treatment was provided. | | | |
| Provide the address of the court or administrative agency. | | | |
| Street | City | State | Zip Code |
| | | | |

| Complete the following if you answered "Yes" to having been hospitalized for a mental health condition | | | |
|---|---|---|---|
| #1 Was the admission voluntary or involuntary? | Provide the dates of treatment. | | |
| ☐ Voluntary Explanation:<br>☐ Involuntary Explanation: | From date (Month/Year) ☐ Est. | To Date (Month/Year) ☐ Est. | |
| Provide the name of the facility where treatment was provided. | | | |
| Provide the address of the court or administrative agency. | | | |
| Street | City | State | Zip Code |
| | | | |

| Questionnaire Continuation | | | | |
|---|---|---|---|---|
| Last Name | First Name | Middle Name | Jr., II, etc. | Last 4 - Social Security Number |
| | | | | |

## Psychological and Emotional Health

The following question asks whether you have been diagnosed with a specified mental health condition that may, particularly if untreated, impact your judgment, reliability, or trustworthiness. If you answer in the affirmative, we will seek additional information about the seriousness and symptoms of the condition, as well as any applicable course of treatment. It is important to note that may such diagnosis, in and of itself, is not a reason to revoke or deny eligibility for a law enforcement position, or fitness to obtain or retain employment. Seeking or receiving mental health care for personal wellness and recovery may contribute favorably to a decision about your eligibility.

Have you EVER been diagnosed by a physician or other health Professional (for example, a psychiatrist, psychologist, licenses clinical social worker, or nurse practitioner) with psychotic disorder, schizophrenia, schizoaffective disorder, delusional disorder, bipolar mood disorder, borderline personality disorder, or antisocial personality disorder?

☐ Yes ☐ No (If NO, proceed to next question)

Complete the following if you answered "Yes" to having ever been diagnosed by a physician or other health professional.

| #1 Identify the diagnosis or health condition. | Provide the dates of diagnosis. From date (Month/Year) ☐ Est. | To Date (Month/Year) ☐ Est. |
|---|---|---|
| Provide the name of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such condition. | Telephone number | |

Provide the address of the health care professional who diagnosed you, or is currently treating you for such diagnosis, or with whom you have discussed such conditions.

| Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Provide the name of any agency/organization/facility where counseling/treatment was provided. | Same as above ☐ | Telephone number |
|---|---|---|

Provide the address of agency/organization/facility where counseling/treatment was provided.

| Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

Was the counseling/treatment effective in managing your symptoms?

☐ Yes ☐ No If no, provide explanation:

| Questionnaire Continuation | | | | |
|---|---|---|---|---|
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| | | | | |

| Psychological and Emotional Health |
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| Answer the following only if you answered, "No" to the above questions. |

Do you have a mental health or other health condition that **substantially adversely** affects your judgment, reliability, or trustworthiness even if you are not experiencing such symptoms today? ☐ Yes ☐ No

(Note: If your judgment, reliability, or trustworthiness is not substantially adversely affected by a mental health or other conditions, then you should answer "no" even if you have a mental or other condition requiring treatment. For example, if you are in need of emotional or mental health counseling as a result of services as a first respo0ndier service in a military combat environment, having been sexually assaulted or a victim of domestic violence, or marital issues, but your judgment, reliability or trustworthiness is not substantially adversely affected, then answer "No.")

| Complete the following if you answered "Yes" to having a mental health or other health condition that **adversely** affects your judgment, reliability, or trustworthiness. | | | |
|---|---|---|---|
| Did you ever receive or are you currently receiving counseling or treatment for that condition? (You may choose not to answer this question. However, such consultation or treatment will not disqualify you and is considered to be a positive action.) | | | |
| ☐ Yes ☐ I decline to answer<br>☐ No If no, provide explanation: | | | |
| If you responded "Yes" to having ever received or you are currently receiving counseling or treatment for that condition. | | | |
| #1 Provide the dates of counseling or treatment. | | Provide the telephone number of the health care professional. | |
| From date (Month/Year) ☐ Est. | To Date (Month/Year) ☐ Est. | Telephone number | |
| Provide the name of the health care professional. | | | |
| Provide the address of the health care professional. | | | |
| Street | City | State | Zip Code |
| Provide the name of any agency/organization/facility where counseling/treatment was provided. | Same as above ☐ | Telephone number | |
| Provide the address of agency/organization/facility where counseling/treatment was provided. | | | |
| Street | City | State | Zip Code |
| Was the counseling/treatment effective in managing your symptoms?<br>☐ Yes ☐ No If no, provide explanation: | | | |

| Questionnaire Continuation | | | | |
|---|---|---|---|---|
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| | | | | |

It is noted, with reference to this questionnaire, that neither your truthful responses nor information derived from your responses to this questionnaire will be used as evidence against you in a subsequent criminal proceeding.

After completion of this form and any attachments you have provided, you should review your answers to all questions to make sure the form is complete and accurate, and then sign and date the following certification and the attached release(s).

## Certification

My statements on this form, and on any attachments to it, are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I have carefully read the foregoing instructions to complete this form. I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both (18 U.S.C. 1001). I understand that intentionally withholding, misrepresenting, or falsifying information may have a negative effect on my eligibility for a law enforcement position, employment prospects, credentialing, or job status, up to and including denial or revocation of my credentials, or my removal and debarment from employment with _____.

I understand my right to obtain a copy of any national criminal history report made available to the _____, and/or Personnel Security Consultants, Inc., and my rights to challenge the accuracy and completeness of any information contained in the report.

| Signature | Printed Name | Date (mm/dd/yyyy) |
|---|---|---|
| | | |

| Enter you Social Security Number before going to the next page → | |
|---|---|

**Authorization for Release of Medical Information Pursuant to the Health Insurance Portability and Accountability Act (HIPAA)**

*If you answered "Yes" to any of the above questions, carefully read this authorization to release information about you, then sign and date it in ink.*

This is an authorization for the investigator to ask your health practitioner(s) the questions below concerning your mental health consultations. _____ recognizes the critical importance of mental health and advocates practice management of mental health conditions to support the wellness and recover of employees and others. _____ recognizes that mental health counseling and treatment may provide important support for those who have experienced traumatic events, as well as for those with other mental health conditions. While most individuals with mental health conditions do not present security risks, there may be times when such a condition can affect a person's eligibility for a Law Enforcement position. Seeking or receiving mental health care for personal wellness and recovery may contribute favorably decisions about your eligibility. Your signature will allow the practitioner(s) to answer only those questions identified below.

Authorization

I am seeking assignment to or retention in a law enforcement position identified in Security Executive Agent Directive 4, National Security Adjudicative Guidelines, 5(b). As part of the investigative process, I hereby authorize the investigator, special agent, or other duly accredited representative of _____ and/or Personnel Security Consultants, Inc., conducting my initial background investigation, reinvestigation, or as part of ongoing evaluation for eligibility for a law enforcement position, and my health practitioner(s) to provide, the information requested below, relating to my mental health consultations.

In accordance with HIPAA, I understand that I have a right to revoke this authorization at any time by writing to my health care provider/entity. Revocation of this authorization is not effective until received by my health care provider/entity. I understand that I may revoke this authorization, except to the extent that action has already been taken based on this authorization. Further, I understand that this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand the information disclosed pursuant to this authorization for use by the _____ only for purposes provided in the Questionnaire for Law Enforcement Positions will no longer be covered by the HIPAA Privacy Rule, and that _____ may re-disclose the information as authorized, subject to Privacy Act safeguards.

Photocopies of this authorization with my signature are valid. The authorization is valid for one (1) year from the date signed or upon affiliation with _____, whichever is sooner.

| Print Name | | Social Security Number ' |
|---|---|---|
| Other Names Used | Current Address | Telephone Number |
| Signature (Sign in ink) | | Date signed (mm/dd/yyyy) |

**For Use By Practitioner(s) Only**

Does the person under investigation have a condition that could impair his or her judgment, reliability, or trustworthiness?

☐ Yes ☐ No

If so, describe the nature of the condition and the extent and duration of the impairment or treatment.

| What is the prognosis? | Dates of treatment: |
|---|---|

| Signature *(Sign in Ink)* | Practitioner Name | Date Signed *(mm/dd/yyyy)* |
|---|---|---|