

EAP Lifestyle Management, LLC
1.800.788.2077
eaplifestyle@EAPLifestyle.com

Affiliate Provider Procedures

- EAP Lifestyle Management, LLC will contact affiliate with referral.
- EAP Lifestyle Management, LLC will fax Authorization Form to provider.
- EAP Lifestyle Management, LLC referred client will contact Affiliate to schedule appointment. (Affiliate is not to leave any messages for appointments or any other reason, without expressed permission of client. If client is a minor according to state law, proof of guardianship is necessary, when indicated, before seeing minor for an individual session.)
- At first session/ office visit, Affiliate requests clients to complete the following forms:
 - Notice of Information (NOI) Acknowledgement Form (Affiliate downloads copy of EAP Lifestyle Management, LLC NOI Practices at www.EAPLifestyle.com and offers to each client or legal guardian.) Form must also be witnessed by office staff.
 - Client Information Form
 - Statement of Understanding
 - Release of Confidential Information
 - Affiliate Provider office staff. Will fill out the client name, provider's name, and expiration date (one year from that day)
 - **Must** be signed by client and **witnessed**
 - EAP Participant Survey (to be completed by each client at conclusion of first session/office visit)
- Affiliate completes Intake using EAP Lifestyle Management, LLC Intake Form and Affiliate Provider Clinical Assessment Form. The Affiliate Provider Clinical Assessment Form must include progress notes for **each** office visit
- Affiliate faxes the following forms to EAP Lifestyle Management, LLC at (251) 621-5361 upon completion of first session/office visit:
 - **NOI Acknowledgement**
 - **Ct. Information Form**
 - **Intake Form**
 - **Consent for Release of Info**
 - **Statement of Understanding**
- For Affiliate Reimbursement, all forms must be submitted to EAP Lifestyle Management, LLC. Additional Forms required are:
 - EAP Lifestyle Management, LLC Contact Form (to be submitted monthly via fax to EAP Lifestyle Management, LLC at: (251) 621-5361)
 - EAP Lifestyle Management, LLC Billing Form (Billing Form may be submitted weekly, monthly, or at case closure.)

Affiliate may copy forms as needed.



EAP Lifestyle Management, LLC
800.788.2077
www.EAPLifestyle.com

Statement of Understanding

Welcome to the Employee Assistance Program!

I understand that Employee Assistance is a free and confidential service for employees and immediate members who are experiencing personal problems.

I understand that during a confidential interview with a consultant, problems will be identified. If specialized or long-term treatment is necessary, referral will be made to the appropriate resource. I understand that assistance is available for marital, family. Emotional. Alcohol, drug, financial, legal, and job problems.

I understand that information shared with EAP consultant will be strictly confidential except for the following:

- 1) Child Abuse
- 2) When danger exists to the self or others
- 3) Court subpoenas (rarely occurs but is possible)

I understand that Employee Assistance is available at no cost. Only when individuals are referred to a community resource will they be responsible for treatment charges. Medical insurance may cover a portion of the cost for additional help required. When making referrals to an appropriate community resource, the EAP consultant will be sensitive to an individual's financial status and available coverage.

If it is my child or ward who will be receiving services, I hereby give my consent for such services.

Please sign if you understand this information.

Signed: _____

Witnessed: _____

Date: _____



EAP Lifestyle Management, LLC
 800.788.2077
www.EAPLifestyle.com

Client Information Form

Welcome to the Employee Assistance Program! We hope the program will help you as it has many others. Please fill out the following:

Name: _____ Date: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: Home: _____ Work : _____ Cell : _____ (ok to leave message: yes or no?) (ok to leave message: yes or no?) (ok to leave message: yes or no?) S.S.#: _____ Date of Birth (mm/dd/yr): _____
Please Check One: 1) Employee _____ Spouse _____ Dependent _____ 2) Male _____ Female _____ 3) Single _____ Married _____ Divorced _____ Separated _____ Widowed _____ If married, how long: _____ 4) Children: (<u>Sex & Age</u>) _____
Company: _____ Job Title: _____ Date of Hire: _____ Work Site/Department: _____ Your Health Insurance Company: _____
Check Information Source: EAP Card/Brochure _____ EAP Orientation _____ Word of Mouth _____ Friend/Relative _____ Supervisor _____ Medical Dept _____ Personnel Office _____ Other(specify)_____

List in order of importance the problem(s) for which you are seeking help and circle the level (Mild, Moderate, or Extreme) you are experiencing of that problem.

_____ Mild Moderate Extreme
 _____ Mild Moderate Extreme
 _____ Mild Moderate Extreme

List the kinds of treatment (if any) received for this problem(s).

Please Circle Those Items That You Are Experiencing.

Loss of pleasure	Feeling fearful
Loss of interest in sex	Trouble falling asleep
Guilt	Irritability
Wishing you were dead	Discouragement about future
Drinking too much alcohol	Others worried about your drinking
Used drugs not for medical reasons	Anxious or worried for 6 months or more
Feeling sad	Fear of going crazy
Drugs caused problems in family, work	Feeling suicidal
Fatigue	Crying
Trouble concentrating	Trouble staying asleep
Depression	Unhappiness
Boredom	Sudden attacks of panic or fear

In the last month, how would you say you or your wife/husband/partner got along?

Very well_____ Not well_____ Fairly well_____ Very poorly_____ No Partner_____

Check the sentence that describes your frequency of drinking alcoholic beverages.

___ I never drink any alcoholic beverages.

___ In a typical week, I might not drink any alcoholic beverages. I just drink once in a while.

___ In a typical week, I usually drink some alcoholic beverage.

Do you smoke marijuana or use any addicting drugs? Yes_____ No_____

List any medications you are taking:

What best describes your mental health in the LAST MONTH?

Excellent_____ Good_____ Fair_____ Poor_____



EAP Lifestyle Management, LLC
800.788.2077
www.EAPLifestyle.com

Request for other ways of communicating with me:

I do not need to provide any reason and simply request the following alternatives to or limitations on communicating with me by you or this practice:

1. Please telephone me ONLY at this number(s): _____

When you call please follow these directions: _____

Please do NOT telephone me at this number(s): _____

2. Please direct all postal mail to this address: _____

Please do NOT send postal mail to this address: _____

3. You may e-mail to me at this address: _____

Signature of client or his/her personal representative

Date





EAP Lifestyle Management, LLC
1.800.788.2077
www.EAPLifestyle.com

NOI Acknowledgement

I have been offered EAP Lifestyle Management, LLC Notice of Information Practices to read,
posted in the offices of EAP Lifestyle Management, LLC. I **DECLINE / ACCEPT**

(Circle one) my right to have a copy of EAP Lifestyle Management, LLC Notice of Information
Practices.

Signature

Date

Print Name

Witness

* If client indicates they **accept** their right to have a copy of Notice of Information Practices,
client must be provided with such. **Notice of Information Practices** can be downloaded at:
www.EAPLifestyle.com



EAP Lifestyle Management, LLC
 Phone:(251) 621-5360 Fax: (251) 621-5361
www.EAPLifestyle.com

EAP Participant Survey

We care about your satisfaction with the EAP and strive to provide each person the highest possible quality of service. By filling out this survey, you will help us maintain that quality. This is an anonymous survey so you do not need to sign it. Thank you for your help.

Company: _____

EAP Counselor: _____

I am: _____ an employee _____ a family member _____ other

Please check one for each:

- | | Very
Satisfied | Satisfied | Disatisfied |
|--|---------------------------|------------------|--------------------|
| 1. My initial call was responded to promptly | _____ | _____ | _____ |
| 2. The EAP was knowledgeable and helpful | _____ | _____ | _____ |
| 3. The office environment was comfortable | _____ | _____ | _____ |
| 4. My concerns were handled in a confidential manner | _____ | _____ | _____ |
| 5. I was satisfied with the outcome of my visit(s) | _____ | _____ | _____ |
| 6. Overall, were you satisfied with EAP? | | Yes_____ | No____ |
| 7. Would you use the program again? | | Yes_____ | No____ |
| 8. Would you recommend the program to a friend? | | Yes_____ | No____ |
| 9. Comments or suggestions: | | | |

Intake

Client Name _____

Date _____

Presenting Problem (duration, intensity, precipitating event):

Family History (abuse, violence, losses):

Client Marital or Relationship History:

Psychiatric History (DX hospitalizations, OP, dates duration, response):

Medical History (medications):

Trauma History:

Work Issues (Disab., LOA, WC, litigation, warning, suspension, relations w/ co-workers and/or supervisors.) :

Mental Status (speech, mood & affect, orientation, thought process, judgment, memory):

Suicide/Homicide Ideation, Plan Attempt, HX, Threat of Violence :

Sleep / Appetite :

Drug / ETOH History (current use and/or abuse, history of use and/or abuse):

Chemical Dependency Tx :

Finances / Legal :

Support Systems :

Cultural Issues :

Rec/Leisure :

Religion/Spiritual :

Other Issues :

DSM IV Diagnostic Impression (Defer, Provisional)

Axis I	
Axis II	
Axis III	
Axis IV	Stressors: Severity:
Axis V	Current GAF: Highest GAF past year:

Plan Recommendation :

Client Instruction for F.U. :

Counselor: _____



EAP Lifestyle Management, LLC
800.788.2077
www.EAPLifestyle.com

Affiliate Provider Clinical Assessment/ Problem Resolution Form

Client Name _____ Employee _____
Family Member _____

Company _____

Names of other attending counseling and their relationship to client

(Cannot see children without legal guardian permission; Affiliate Provider responsible for obtaining verification of guardianship and for assuming knowledge of state laws regarding age of consent)

NAME	RELATIONSHIP TO CLIENT

Progress Notes From Each Office Visit (needs to include brief summary of session; current status of client; any recommendations & goals for client; etc):

Date: _____

Date: _____

Date: _____

Date: _____

Referral Data:

- No referral made
- Referral made – please specify: _____

(Affiliate provider assumes responsibility to make every effort to match insurance coverage and/or ability to pay to referral source; for assistance with referrals, please contact EAP Lifestyle Management, LLC at 800-788-2077.)

Affiliate Provider Signature/ Credentials

Date signed



EAP LIFESTYLE MANAGEMENT, LLC
1605 MAIN STREET
DAPHNE, ALABAMA 36526
PHONE (251) 621-5360
FAX (251) 621-5361
www.EAPLifestyle.com

BILLING FORM

Client Name: _____

Client Company: _____

Affiliate Provider Name: _____

Tax ID Number: _____ (or) SSN: _____

Address: _____

Phone Number: (_____) _____

Date(s) of Office Visits:

Total Amount Due: _____

Issue Resolved? Yes / No

Client was Referred? Yes / No

State Referral Source: _____

Additional Comments: _____

Thank you for your assistance!

Signature / Credentials

Printed Name / Credentials

Date Submitted

**EAP Lifestyle Management, LLC
to complete:**

* Date record: _____

* Date paid: _____

*EAP Lifestyle Management, LLC staff
must complete upon receipt.