

Dear Associate,

Thank you for agreeing to provide services on our behalf. The following pages contain documents required for our files.

Please have the **Management Referral** client(s) complete the "EAP Intake Information" form, the "Employee Assistance Information Release Form" and the "Conditional Participation Agreement". Each individual must also be provided with the **Statement of Understanding – Employee Assistance Services** and **Notice of Privacy Practices – H&H Health Associates, Inc.** included in this packet. The client will acknowledge receipt of these policies with their initials on the "EAP Intake Information" form.

The "Employee Assistance Information Release Form" is to be faxed or emailed to our office immediately after the initial session.

The "Management Referral Report" page is to be filled out by you, and faxed or emailed to our office **after each session (or cancellation)** with the client.

The "EAP Clinical Discharge Summary" page is to be filled out by you, with the exception of the **Personal Assessment**. (This section was originally completed by the client on the "EAP Intake Information" form, and is designed to measure their perception of progress or lack thereof).

Finally, for fast payment processing, we ask that you record session activity on the "Authorization of Service" form you should have received from us and return this with any progress notes, the "EAP Intake Information" and "EAP Clinical Discharge Summary", "Employee Assistance Information Release", and the "Conditional Participation Agreement" forms.

Thank you again. Please feel free to contact us with any questions or comments.

H&H Health Associates, Inc.
11132 South Towne Square
Suite 107
St. Louis, MO 63123
Attention: Intake Department
314.845.8302 / 800.832.8302
314.845.8087 – Fax
counsel@hhhealthassociates.com

EAP INTAKE INFORMATION

Today's Date: _____

CLIENT INFORMATION

Last name	First name	Middle

EAP Services are available to me through:

My employer <input type="checkbox"/>	Spouse's employer <input type="checkbox"/>	I am a dependant <input type="checkbox"/>
Other <input type="checkbox"/> Explain: _____	Company name: _____	

GENERAL BACKGROUND

 What brings you to the EAP today? _____

PERSONAL ASSESSMENT:

Recently I have had job performance difficulties:	None <input type="checkbox"/>	Slightly <input type="checkbox"/>	Moderately <input type="checkbox"/>	Frequently <input type="checkbox"/>
Recently I have had difficulty with normal social activities:	None <input type="checkbox"/>	Slightly <input type="checkbox"/>	Moderately <input type="checkbox"/>	Frequently <input type="checkbox"/>
My current physical health is:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>

 How many days of work have you missed or been tardy in the past month?

Married/Separated/Divorced (dates): _____

Dependent(s) Name(s)/age(s): _____

Medical Conditions and Medications: _____

Dates, Duration, and providers of all past counseling: _____

I acknowledge that a "Statement of Understanding-Employee Assistance Services" was provided to me and any questions I had were answered to my satisfaction.

Initial

I acknowledge that a "Notice of Privacy Practices H&H Health Associates, Inc." (HIPAA Policy) was provided to me and any questions I had were answered to my satisfaction.

Initial

Signature: _____

I (we) give consent to H & H Health Associates, Inc. to provide counseling services for _____

(minor child) for whom I am responsible. Guardian's Signature: _____



Statement of Understanding Employee Assistance Services

I understand the following:

The decision to receive services from the Employee Assistance Program (EAP) is strictly voluntary even though clients are sometimes referred to the program by family members, supervisors, union officials, medical staff, and/or other health care professionals.

Our Services:

All services provided by the EAP are at no cost to you or your family members. The EAP contract with your employer allows for a specified number of sessions; however, the number of sessions necessary to assist you is a clinical decision which will be made by your EAP counselor. Cancellations of appointments should be made 24 hours in advance. Only in the case of emergency will the session be interrupted.

The services offered by the EAP include problem assessment, short-term counseling, referral as deemed necessary, and follow-up. Formal medical diagnoses or on-going treatment services are not provided. Such services are provided by qualified professional agencies and individuals in the community.

The EAP services provided to you may include referring you to independent medical or mental health resources for on-going assistance. If a referral is made, the EAP will usually provide two or three resource options. The final choice will be your responsibility. These referrals are made in consideration of our assessment of your needs. The EAP receives no reimbursement from any referral source.

If a referral for on-going treatment services is required, your EAP counselor will consider your insurance benefits and ability to pay, and will discuss these matters with you. However, you are responsible for final verification of insurance coverage and any co-payments or charges not covered by your insurance.

Confidentiality/Access to Privileged Information:

All case records and information about clinical services provided to you by the EAP will be maintained in the strictest confidence possible under law.

Specific information contained within your case records will not be released to any party without your written authorization except pursuant to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 and Missouri state or Federal law. These include reporting abuse, neglect and domestic violence; addressing serious threats to health or safety; and law enforcement purposes.

If you wish to contact us for further information or to file a complaint, please contact Tim Hobart, Privacy Officer, telephone 314.845.8302.

Your initials submitted on the enclosed “EAP Intake Form” acknowledge consent to this policy.



NOTICE OF PRIVACY PRACTICES H&H HEALTH ASSOCIATES, INC.

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We will not disclose your protected health information to third parties without your written authorization or other authority under the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Regulations"). We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our privacy notice and to make the new notice provisions effective for all protected health information we maintain. In the event we should change our privacy notice, we will provide you with a revised notice at your next visit. We must promptly revise and distribute this notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in this notice. Except when required by law, a material change to any term of this notice may not be implemented prior to the effective date of the notice in which such material change is disclosed to you.

Your written authorization and specific provisions of the Privacy Regulations govern disclosure of your protected health information. Disclosures not described in this and the next paragraph may be made only with your written authorization, which you may revoke in writing as provided in the Privacy Regulations. The company is permitted under the Privacy Regulations to use and disclose protected health information for treatment, payment and health care operations. For example, protected health information may be disclosed from one staff member to another within the company for consultation.

Subject to requirements of the Privacy Regulations, we may use and disclose protected health information for purposes of complying with legal requirements; public health activities; reporting abuse, neglect and domestic violence; cooperation with health oversight by government agencies and as required by the Secretary of Health and Human Services for compliance with the Privacy Regulations; for judicial and administrative procedures; for law enforcement; with respect to decedents; regarding cadaveric organ, eye and tissue donation; serious threats to health or safety; specialized in government functions; and incident to a use or disclosure otherwise permitted or required by the Privacy Regulations, as provided under the Privacy Regulations. We may also disclose protected health information pursuant to your agreement to persons indicated by you for involvement in your health care for notification purposes.

Missouri state laws with respect to genetic information and to human immunodeficiency virus infection status are more stringent than the Privacy Regulations and protected health information regarding these matters will be disclosed only in accordance with the governing Missouri statutes.

You have certain rights with regard to the handling of your protected health information, as provided in the Privacy Regulations, these are as follows: You may request restrictions on certain uses and disclosures of protected health information however, we are not required to agree to a requested restriction; You may receive confidential communications of protected health information as provided by the Privacy Regulations; You may inspect and copy your protected health information, pursuant to a written request, subject to certain restrictions in the Privacy Regulations, such as restriction on access to psychotherapy notes; You have a right to appeal a denial of access to your records; You may request an amendment of protected health information and demographic information, pursuant to a written request, subject to certain limitations in the Privacy Regulations; You have a right to contest a denial of an amendment; You may receive an accounting of certain disclosures of protected health information; You may obtain a paper copy of this notice upon request and a copy of your written acknowledgement of receipt of this notice.

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. If you wish to contact us for further information or to file a complaint, please contact Tim Hobart, Privacy Officer, telephone 314.845.8302. We will not take any action against you for filing a complaint or for exercising your rights under the Privacy Regulations.

Your initials submitted on the enclosed "EAP Intake Form" acknowledge consent to this policy.

EMPLOYEE ASSISTANCE INFORMATION RELEASE FORM

I, _____, hereby consent to the release/exchange of information as deemed pertinent by H&H Health Associates, to _____ for purposes of establishing and coordinating an effective treatment plan.

Purpose(s)

To facilitate referral for treatment/ to verify compliance with EAP recommendations/ Utilization Management

Check all applicable reasons

<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Medication History/ Current
<input type="checkbox"/> Intake Assessment	<input type="checkbox"/> Lab Report
<input type="checkbox"/> History/Treatment Plan /Discharge Summary	<input type="checkbox"/> Referral/Recommendation
<input type="checkbox"/> Psychiatric Exam/Evaluation	<input type="checkbox"/> Current Status
<input type="checkbox"/> Progress/Prognosis	<input type="checkbox"/> Other

Signature of Client of Participant:

Date:

Signature of Witness:

Signature of Parent/Guardian:

For Management Referrals Only

For the purpose of verifying compliance with EAP recommendations, I, _____ hereby authorize and consent to the release of the following information by the EAP to the referring supervisor/manager (name) _____.

1. Whether I have kept appointment as scheduled
2. Whether or not I am fully cooperating with EAP treatment recommendations and plans
3. Whether I need time away from work
4. Whether I present a safety concern at work or to co-employee

MANAGEMENT REFERRAL REPORT

Please fax after each appointment: 314.845.8087

Name of Employee:	
<input type="checkbox"/> Has	<input type="checkbox"/> Has not kept the scheduled appointment
<input type="checkbox"/> Is	<input type="checkbox"/> Is not fully cooperating with EAP treatment recommendations and plans
<input type="checkbox"/> Needs	<input type="checkbox"/> Does not need time away from work
Fill out only if pertinent to this particular case.	
<input type="checkbox"/> Does not appear to present a safety concern at work or to co-employees	
Date:	
H&H Health Associates will complete this section	
To:	<i>(Name of supervisor to whom report is sent)</i>
	<i>(Title)</i>
	<i>(Company name)</i>
	<i>(Address)</i>
Comments:	
Counselor Signature:	

CONDITIONAL PARTICIPATION AGREEMENT

The following represents the recommended conditions to participate in the H&H Health Associates Employee Assistance Program. The employee's signature indicates an understanding and acceptance of the following conditions. Noncompliance of any of these conditions can result in your dismissal from the H&H Health Associates Employee Assistance Program.

This agreement is not a guarantee of employment, nor does it create any employment contract for the period specified. Employee will remain subject to all terms and conditions of employment in addition to those in this agreement.

_____ Initial	1. You are expected to successfully comply with the recommended treatment plan as outlined by the Employee Assistance Program consultant and any treatment personnel involved in your treatment plan.
_____ Initial	2. You are expected to keep appointments with the EAP counselor. The EAP will not be able to see a person 20 minutes late. The employee will be expected to make the next appointment through the referring source.
_____ Initial	3. You are expected to complete the aftercare of follow-up plan that may include your participation in a 12-step program. You will be required to provide documentation of your attendance to the EAP consultant.
_____ Initial	4. You are expected to abstain at all time from the use of alcohol and any mood altering chemicals, unless prescribed by your doctor. In the event a mood altering substance is prescribed, you are required to notify the EAP of the type, dosage and period of time you will be taking the prescription drug.
_____ Initial	5. You may be required to submit to random drug/alcohol testing. If a positive test occurs, it may result in your dismissal from H&H Health Associates Employee Assistance Program.
_____ Initial	6. During conditional participation in the EAP you are expected to perform your work responsibilities as required by your employer.
Other:	

These conditions will be in effect for the term of _____ as recommended by the EAP consultant.

I _____, understand and accept the terms and conditions of my conditional participation in the H&H Health Associates Employee Assistance Program and consent to treatment by H&H Health Associates.

Employee Signature

Date

The Employee Assistance Counselor made these recommendations on the basis of information that I have supplied, however, I have decided not to follow the recommendations that were made to me. I also understand that my case will be closed at this time.

Employee Signature

Date

EAP Consultant Signature

Date

H&H Health Associates, Inc.
EAP CLINICAL DISCHARGE SUMMARY

Client Name(s):				
Closing Date:				
Resolution/ Closing Recommendation: (Following section based on counselors assessment):				
Issue resolved	<input type="checkbox"/>			
Referred to an outside resource	<input type="checkbox"/>			
Referred to an internal resource	<input type="checkbox"/>			
Outcome in the Workplace:				
Improved:	Morale <input type="checkbox"/>	Productivity <input type="checkbox"/>	Absenteeism <input type="checkbox"/>	No Change <input type="checkbox"/>
Global Assessment of Functioning (GAF)	Decrease <input type="checkbox"/>		Increase <input type="checkbox"/>	No Change <input type="checkbox"/>
Achievement of Counseling Goals:	No <input type="checkbox"/>		Partly <input type="checkbox"/>	Yes <input type="checkbox"/>
Performance Impairment:	Deteriorated <input type="checkbox"/>		Improved <input type="checkbox"/>	No Change <input type="checkbox"/>
Absence:	Deteriorated <input type="checkbox"/>		Improved <input type="checkbox"/>	No Change <input type="checkbox"/>
Client Satisfaction Survey Distributed:	Yes <input type="checkbox"/>			No <input type="checkbox"/>
DSMIV-R:				
Axis I:	Axis II:		Axis III:	
Axis IV:	Axis V:			
PERSONAL ASSESSMENT (BASED ON CLIENT'S RESPONSES):				
Recently I have had job performance difficulties:	None <input type="checkbox"/>	Slightly <input type="checkbox"/>	Moderately <input type="checkbox"/>	Frequently <input type="checkbox"/>
Recently I have had difficulty with normal social activities:	None <input type="checkbox"/>	Slightly <input type="checkbox"/>	Moderately <input type="checkbox"/>	Frequently <input type="checkbox"/>
My current physical health is:	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
How many days of work have you missed or been tardy in the past month? <input style="width: 50px;" type="text"/>				
Clinician Signature:				
Clinician Name (Print):				
Clinician Direct Phone:				
E-mail Address:				