



ACKNOWLEDGEMENT OF RECEIPT, REVIEW AND UNDERSTANDING

**NOTE:** Return the signed and dated acknowledgement on or before seven (7) days of receipt of this authorization. Return by fax to: (414) 359-6717 or mail to FEI Behavioral Health, 11700 West Lake Park Drive, Milwaukee, WI 53224

***CLAIMS RECEIVED MORE THAN THIRTY (30) DAYS AFTER THE EXPIRATION DATE OF THE AUTHORIZATION WILL BE DENIED.***

1. Overview of FEI Behavioral Health EAP Process & Referral Facilitation
2. FEI Behavioral Health EAP Claim Form
3. FEI Behavioral Health EAP Closing Form
4. Statement of Understanding – Client
5. Self-Assessment Form – Client
6. Authorization for Disclosure of Protected Health Information – Client

**NOTE:** By signing this document you acknowledge receipt of these forms and agree to file the appropriate forms as described on this Acknowledgement Form and the attached pages.

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Signature of Agency/Provider

Date

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Printed name of Agency/Provider

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Printed Client name (will be attached to Claim file)

## **OVERVIEW OF EAP PROCESS & REFERRAL FACILITATION**

### **FEI Behavioral Health Employee Assistance Programs**

- The EAP Counselor conducts initial session/s (typically 1 or 2) to fully assess the problem/s and situation.
- The EAP Counselor formulates a treatment plan that features the least restrictive, solution focused, brief treatment needed to ameliorate the problem.
- The EAP Counselor reviews the plan with the client upon completion of the assessment process.
- If/as appropriate, the EAP Counselor provides short-term counseling within the EAP when the problem can be resolved within the total number of available EAP sessions.
- Or, if apparent that the client's problem will require treatment beyond the scope of the available EAP sessions, the EAP Counselor refers the client to a treatment provider or community resource suitable to address the nature and severity of the problem. This is typically best done after completion of the assessment.
- In making recommendations for further treatment, the EAP Counselor helps facilitate appropriate care by working with the client and/or health plan to identify pre-certification requirements and network provider options. If you have specific providers or facilities in mind that you think are well suited for the client, check to see if they are in the health plan's network. EAP Counselors are advised to identify three treatment provider referral options, as appropriate and available, who specialize in treating the client's problem (i.e., depression, anxiety disorder). This allows the client to have options in choosing who they will continue to see for treatment.
- The EAP Counselor must also provide the client with three referral options, even when one of the options, as appropriate and desired by the client, is a referral to him/herself as an ongoing treatment provider. If the EAP Counselor is not in the client's behavioral health care network, and the client still wishes to remain with them, they can do so only after review of network options provided and agreement on fee and self-pay arrangements.
- Telephone follow-up with EAP clients should be conducted within 2 weeks of case closure. Follow-up is intended to check on client progress and well-being, to ensure that a connection to treatment has been established for those referred beyond the EAP, and to support treatment follow-up when clients haven't yet established this connection. Follow-up contact should be noted as required on the EAP Case Closing Form.
- EAP services and on-going behavioral health treatment have different purposes and are not intended to serve as benefit extensions of each other. Review and provisions are in place to ensure their distinct purposes and that the EAP benefit is used appropriately.
- Authorization and reimbursement for any treatment beyond the EAP benefit is made by and under the health plan at its discretion in line with benefit levels, coverage available, pre-certification, and/or medical necessity criteria. Payment for treatment is made directly to the provider or his/her organization, and not to FEI Behavioral Health. These authorization, reimbursement, and payment conditions apply in all situations, even if the treatment provider is the EAP Counselor who saw the client through the EAP as an EAP Affiliate of FEI Behavioral Health.

**FEI BEHAVIORAL HEALTH EAP CLAIM FORM – updated 9/2010-----**

Return the following THREE forms to FEI ONLY within 90 days of initial session for payment:  
1) Claim Form 2) Statement of Understanding 3) EAP Client Self-Assessment. All Claim Forms must also be returned within 30 days from expiration date of authorization. Failure to do so can result in denial of payment.

**Send or fax to: FEI Behavioral Health, 11700 West Lake Park Drive, Milwaukee, WI 53224  
Fax #: 414-359-6717 Phone #: 800-782-1948, ext 6602**

**Authorization #:** \_\_\_\_\_ **Date Authorized:** \_\_\_\_\_ **Employee's Company:** \_\_\_\_\_

**AFFILIATE INFORMATION**

Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Service Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**CLIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Relationship to Employee:  Self  Spouse  Child  Adult Dependent  Other Extended Household Member (specify): \_\_\_\_\_

**PROBLEM AREAS – Mark "P" for the Primary Problem (indicate only one) and "S" for all Secondary Problems that apply:**

**WORK RELATED**

- \_\_\_ Absenteeism/Tardiness
- \_\_\_ Work Quantity/Quality
- \_\_\_ Co-Worker/Peer Relations
- \_\_\_ Supervisor/Manager Relations
- \_\_\_ Customer/Vendor Relations
- \_\_\_ Work Place Violence
- \_\_\_ Safety Violations/Accidents
- \_\_\_ Positive Drug Screen
- \_\_\_ Roles/Duties/Responsibilities
- \_\_\_ General Job Stress
- \_\_\_ Organizational Change
- \_\_\_ Career Issues
- \_\_\_ Job Loss
- \_\_\_ Other Work Related Issue

**PSYCHOLOGICAL/EMOTIONAL**

- \_\_\_ Depression/Affective Disorder
- \_\_\_ Anxiety/Panic Disorder
- \_\_\_ Psychotic Disorder
- \_\_\_ Eating Disorder
- \_\_\_ Personality Disorder
- \_\_\_ Phase of Life Transition
- \_\_\_ Grief/Bereavement
- \_\_\_ Gambling Problem
- \_\_\_ Other Psychological/Emotional Problem

**FAMILY/COUPLE/INTERPERSONAL**

- \_\_\_ Marital/Couple
- \_\_\_ Separation/Divorce
- \_\_\_ Child/Adolescent Behavior &/or Parenting Issue
- \_\_\_ Academic/School
- \_\_\_ Domestic or Dating Abuse
- \_\_\_ Family/Other Substance Abuse or Dependence
- \_\_\_ Child Abuse/Neglect
- \_\_\_ Childcare
- \_\_\_ Eldercare
- \_\_\_ Other Relationship/Interpersonal Problem

**DRUG ABUSE/DEPENDENCE - SELF**

- \_\_\_ Cocaine
- \_\_\_ Marijuana
- \_\_\_ Narcotics/Opioids
- \_\_\_ Amphetamines
- \_\_\_ Prescription Drugs
- \_\_\_ Other Drug/s

**MEDICAL PROBLEM**

- \_\_\_ Smoking
- \_\_\_ Weight
- \_\_\_ Catastrophic Illness
- \_\_\_ Other Medical Issue

**FINANCIAL ISSUE**

**LEGAL ISSUE**

**ALCOHOL ABUSE/DEPENDENCE - SELF**

*(for NTSB, Philips & Xerox only)*  
**FAILED 1<sup>st</sup> SESSION/NO FURTHER CONTACT**

**EAP SESSION DATES/ATTENDANCE (complete for sessions held and for FEI reimbursable-only "no show" failed session/s)**

<u>Session #</u>	<u>Session Date/s</u>	<u>Clinician</u>	<u>All present in session-names/relationship to client (specify NS if "no show")</u>
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

**EAP CASE OUTCOME**  EAP Case in Process  EAP Case Closed (*must complete/attach Case Closing Form*)

I/we certify that the identified services have been rendered to this client and that all information on this form is accurate and complete.

_____	_____	_____	_____
Clinician Signature	Date	EAP Coordinator Signature	Date

**FEI BEHAVIORAL HEALTH EAP CASE CLOSING FORM – updated 9/2010-----**

This Form must be completed and signed after the EAP case is closed AND the follow-up is complete. All forms must be fully completed as instructed and returned to FEI ONLY within 30 days of expiration date of the authorization date listed on the FEI BEHAVIORAL HEALTH EAP CLAIM FORM. Failure to do so can result in denial of payment.

**Send or Fax to: FEI Behavioral Health, 11700 West Lake Park Drive, Milwaukee, WI 53224  
Fax #: 414-359-6717 Phone #: 800-782-1948, ext 6602**

Authorization #: \_\_\_\_\_ Date Authorized: \_\_\_\_\_ Employee's Company: \_\_\_\_\_

**AFFILIATE INFORMATION**

Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Service Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**CLIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SSN#: \_\_\_\_/\_\_\_\_/\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

**CASE CLOSING REASON: (check only one)**

- 1.  EAP process completed; no further sessions/services needed
- 2.  Client failed first appointment; no further contact from client (for reimbursable "no show" failed appointments only)
- 3.  Client withdrew **and** (check one)  Some progress made **OR**  Issues remain unresolved
- 4.  Client referred beyond EAP: Referrals made: (check all that apply)
  - Outpatient  IOP  Detox  Inpatient/Residential  Psychiatrist  PCP
  - Self Help Group/s (specify) \_\_\_\_\_  Other Community Resource (specify) \_\_\_\_\_
  - 4.a.  **Client agreed to referral/s** **OR**  **Did not agree to referral/s:** (if not, specify reason) \_\_\_\_\_
  - 4.b. **Was the above referral/s made through (check all that apply):**  Insurance of company that sponsors EAP  
 Other Insurance  Client Self-Pay  No Cost Assistance (i.e., self-help group such as AA or Al-Anon)
  - 4.c. **Was one of the referrals to you or your organization?**  Yes  No
    - 4.c.i. **If yes**, did the client select you or your organization for ongoing treatment?  Yes  No
    - 4.c.ii **And**, were at least 2 other referral sources for this level of care provided to the client?  Yes  No
- 5.  Other reason (specify) \_\_\_\_\_

**EAP CASE CLOSING & CLIENT FOLLOW-UP SUMMARY**

**Client follow-up by phone must occur within 2 weeks of last EAP session**

Rate severity of the client's primary problem at case closing: \_\_\_\_ minimum \_\_\_\_ minor \_\_\_\_ moderate \_\_\_\_ severe \_\_\_\_ extreme

Rate your perceptions of client's progress on the following on a scale of : 1 = excellent; 2 = very good; 3 = good; 4 = fair; 5 = poor

Reduction in presenting symptoms \_\_\_\_ Resolution of primary problem \_\_\_\_ Resolution of secondary problems \_\_\_\_

Was direct phone contact made with client for follow-up?  Yes (date): \_\_\_\_/\_\_\_\_/\_\_\_\_  No (specify): \_\_\_\_\_

Has client followed-up with referral/s if made?  Yes  No  No referrals made  No information

I/we certify that the identified services have been rendered to this client and that all information on this form is accurate and complete.

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
EAP Coordinator Signature

\_\_\_\_\_  
Date

## STATEMENT OF UNDERSTANDING

### FEI Behavioral Health Employee Assistance Programs

Must Be Signed By Client at Initial Session

#### EAP Eligibility, Services and Costs

Your Employee Assistance Program (EAP) is provided through FEI Behavioral Health and offers confidential service to all eligible employees and their covered family members to help address issues impacting quality of life, emotional well being and productivity at work. Services are provided by the EAP at no cost to you, and can include assessment/consultation, brief counseling and referral to service providers and/or community resources outside the EAP should this be needed to help resolve your concerns. You are responsible for any costs associated with services beyond the EAP benefit. As these expenses may be covered in part or full under your medical plan, you should contact your plan prior to the onset of this care for specific information on coverage and benefit authorization.

#### Confidentiality

EAP services are strictly confidential. No information concerning your use of EAP will be disclosed to any party outside the EAP except in the following circumstances:

- you consent in writing
- you request that EAP speak with your health plan provider to assist in benefits verification for treatment recommended beyond EAP
- the law requires disclosure to appropriate parties, such as in a court subpoena, or when the life or safety of an individual is deemed at risk or seriously threatened.

**Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 the privacy of your health information is protected by law. FEI Behavioral Health maintains a “Notice of Privacy Practices” that describes how your protected health information may be used and disclosed and how you can obtain. Call your toll free EAP number to receive a copy of this document.**

#### Participation

Use of the EAP is voluntary and your employment will in no way be affected by your use of this program. However, participation in the EAP does not prevent your employer from taking actions regarding unacceptable work performance or behavior. If you were referred to the EAP by your company’s management due to a work performance problem, the EAP will not advise them of your participation without your written consent, on a separate *Disclosure of Confidential Information* form.

#### Cancellation Policy

Should you need to cancel an EAP appointment you must notify your EAP Counselor at least 24 business hours prior to the scheduled appointment. Failure to do so may subject you to direct billing from the EAP Counselor or their organization. EAP reserves the right to terminate services when appointments are cancelled without appropriate notification.

**I have read and understand the above information:**

\_\_\_\_\_  
**Signature of Client (or parent/guardian)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of FEI Affiliate EAP Counselor**

\_\_\_\_\_  
**Date**

**FEI Behavioral Health Employee Assistance Programs**  
**Authorization for Disclosure of Protected Health Information**

Must be signed by every client at initial session

I, \_\_\_\_\_, (*first and last name of EAP client*) authorize both FEI Behavioral Health (FEI) Employee Assistance Program (EAP) and its Counseling Affiliate \_\_\_\_\_ (*name of affiliate*) as represented by \_\_\_\_\_ (*name of counselor*) to disclose to each other the following specific information:

- referral information and assessment findings
- treatment planning and recommendations
- attendance, compliance and progress
- any information required for service authorization, benefit coverage or for payment purposes
- any information required for administration of the EAP program or services

The purpose of this Authorization is to facilitate provision of services to client, to provide for verbal or written communication of information between parties involved, and to manage and pay for those services.

I understand that my EAP records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I agree to release FEI Behavioral Health and its EAP Affiliates from liability that may result from furnishing this information as authorized in this disclosure. I further acknowledge that the nature of the information to be disclosed has been fully explained to me, and this consent is given of my own free will. I understand that I may revoke this consent at any time, except to the extent that FEI Behavioral Health has already taken action in reliance on it.

I may revoke this Authorization by sending a written revocation to: **Privacy Officer, FEI Behavioral Health, 11700 West Lake Park Drive, Milwaukee, WI 53224**. If not previously revoked, this consent will terminate one (1) year after the date I sign this form. I further understand that the information described above may be disclosed to and received by persons or organizations who are not subject to federal information privacy laws. These persons or organizations may further disclose the information and it may no longer be protected by federal information privacy laws.

I acknowledge that a copy of this Authorization has been provided to me and that a copy of this disclosure will be kept as part of the EAP records. I understand that I have a right, upon written request, to inspect and receive a copy of my protected health information, including any information disclosed under this Authorization.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Title of Witness: \_\_\_\_\_ EAP Affiliate Organization: \_\_\_\_\_