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, 648 N. Plankinton Ave., Suite 425, Milwaukee, WI 53203
CLAIMS RECEIVED MORE THAN THIRTY (30) DAYS AFTER THE EXPIRATION DATE OF THE AUTHORIZATION WILL BE DENIED.

The following material(s) have been received and acknowledged:

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

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.

_____

Signature of Agency/Provider Date

_____

Printed name of Agency/Provider

_____

Printed Client name (will be attached to Claim file)

Overview of EAP Process & Referral Facilitations

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.

Statement of Understanding
FEI Behavioral Health Employee Assistance Programs

*Must Be Signed By Client at Initial Session and returned to FEI

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

Client Self-Assessment Form

FEI Behavioral Health Employee Assistance Programs

All information provided is strictly confidential as specified on the EAP Statement of Understanding. Should you have any questions, please speak with your EAP Counselor or call your toll-free EAP telephone number.

Name: _____

Please specify the company you are using your EAP benefit under:

_____

Race/ethnic origin (optional)

[ ] Caucasian
[ ] African American
[ ] Latino/Latina
[ ] West Indian Islander
[ ] Asian/Pacific Islander
[ ] Native American
[ ] Other (specify):
_____

Please circle how you would describe your current functioning:

At home with family	excellent	very good	good	fair	poor
With friends and acquaintances	excellent	very good	good	fair	poor
Balancing work, family and other areas	excellent	very good	good	fair	poor
Ability to focus on my work	excellent	very good	good	fair	poor
Productivity at work	excellent	very good	good	fair	poor
Attendance at work	excellent	very good	good	fair	poor
Relationships at work	excellent	very good	good	fair	poor

Please indicate the frequency of which you have been experiencing the following within the past month:

Sadness	all the time	often	sometimes	rarely	never
Loss of interest or enthusiasm	all the time	often	sometimes	rarely	never
Hopelessness about the future	all the time	often	sometimes	rarely	never
Concentration difficulties	all the time	often	sometimes	rarely	never
Anxiety	all the time	often	sometimes	rarely	never
Relationship problems	all the time	often	sometimes	rarely	never
Use of alcohol	all the time	often	sometimes	rarely	never
Use of non-prescription drugs	all the time	often	sometimes	rarely	never
Sleep difficulties	all the time	often	sometimes	rarely	never
Appetite changes	all the time	often	sometimes	rarely	never
Health problems	all the time	often	sometimes	rarely	never
Stress	all the time	often	sometimes	rarely	never

Do you ever drink alcoholic beverages? [ ] Yes [ ] No If yes, please answer the following:

Have you ever thought you should cut down on your drinking?	[ ] Yes	[ ] No
Have you ever felt annoyed by other's criticism of your drinking?	[ ] Yes	[ ] No
Have you ever felt guilty about your drinking?	[ ] Yes	[ ] No
Do you have a morning "eye opener"?	[ ] Yes	[ ] No

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

*Must Be Signed By Client at Initial Session and returned to FEI

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, 648 N. Plankinton Ave., Suite 425, Milwaukee, WI 53203.** 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: _____

FEI Behavioral Health EAP Claim Form

Return this claim form and the Statement of Understanding within 90 days of the initial session to insure payment. Claims for subsequent sessions must be submitted, using this form, within 30 days of the expiration date of the authorization, to insure payment. **Mail to:** FEI Behavioral Health, 648 N. Plankinton Ave., Suite 425, Milwaukee, WI 53203 **Fax to:** 414-359-6717 **For Claims Information Call:** 800-782-1948 opt. 4

Authorization Number: _____ Date Authorized: _____

Employee's Company Name: _____ Affiliate Name: _____

Agency/Org Name:_____ Phone: ( )_____

Service Address: _____ City:_____ State: _____ Zip Code:_____

CLIENT INFORMATION

Last Name: _____ First Name:_____

Address: _____City:_____ State:_____ Zip Code:_____

☐Employee ☐Spouse ☐Domestic Partner ☐Dependent Adult ☐Extended Household (specify) _____

PROBLEM AREAS

Is the affiliate-assessed primary presenting problem the same as that indicated on the authorization? ☐Yes ☐No

If Yes, proceed to the next section. If No, mark "P" next to the appropriate affiliate assessed primary problem below.
Mark "S" for up to 2 Affiliate-assessed secondary presenting problems in addition to any indicated in the authorization.

Work-Related

- ☐ Attendance
- ☐ Career Issue
- ☐ Interpersonal-Co-worker
- ☐ Interpersonal-Manager
- ☐ Interpersonal-Vendor/Customer
- ☐ Job Loss
- ☐ Post-Trauma-Work
- ☐ Safety/Accident-Work
- ☐ Violence Aggression-Work
- ☐ Other Work
- ☐ Alcohol Abuse-Self
- ☐ Financial Issue
- ☐ Legal Issue
- ☐ Gender Identity Issue
- ☐ Academic Problem

Psychological/Emotional

- ☐ Addictive Behavior Non-Alcohol/Drug
- ☐ Anxiety
- ☐ Depression
- ☐ Grief Bereavement/Loss
- ☐ Phase of Life Transition
- ☐ Serious Persistent Mental Illness
- ☐ Violence/Aggression/Anger
- ☐ Other Psychological/Emotional

Drug Abuse/Dependence

- ☐ Amphetamine-Self
- ☐ Cocaine-Self
- ☐ Opioid-Self
- ☐ Prescription-Self
- ☐ THC/Marijuana-Self
- ☐ Other Drug Abuse Dependence-Self

Family/Marital/Other Interpersonal

- ☐ Alcohol Abuse Family/Other Pers.
- ☐ Substance Abuse Family/Other Pers.
- ☐ Addictive Behavior/Family/Other Pers.
- ☐ Marital/Couple
- ☐ Family
- ☐ Child Adolescent/Parenting
- ☐ Dependent Care
- ☐ Domestic Abuse
- ☐ Interpersonal Non-Family
- ☐ Other Family/Marital/Interpersonal

Medical

- ☐ Medical Event-Self
- ☐ Medical Catastrophic-Self
- ☐ Medical Chronic-Self
- ☐ Sexual Dysfunction
- ☐ Other Medical

EAP SESSION DATES AND ATTENDEES

Session Number	Date	Clinician Name	Attendees (all present in session & relationship to client)

CASE STATUS

☐ EAP Case in Process ☐EAP case closed – must complete and attach Case Closing Form

CERTIFICATION

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

This form must be completed and signed after the EAP case is closed AND follow-up is completed. All forms must be submitted exclusively to FEI Behavioral Health within 30 days following the expiration date of the EAP authorization. Failure to comply may result in denial of payment. **Mail to:** FEI Behavioral Health, 648 N. Plankinton Ave., Suite 425, Milwaukee, WI 53203 **Fax to:** 414-359-6717 **For Claims Information Call:** 800-782-1948 opt. 4

Authorization Number:_____ Date Authorized:_____ Employee's Company:_____

AFFILIATE INFORMATION

Affiliate Name: _____Phone: (___) _____

Address: _____City:_____ State:_____ Zip Code: _____

CLIENT INFORMATION

Last Name: _____ First Name:_____

Address: _____City:_____ State:_____ Zip Code:_____

CASE CLOSING REASON

☐ Client failed first appointment and did not reschedule.
☐ Client discontinued before EAP plan completed.
☐ EAP process Completed. No further sessions or referral services needed.

Did client continue with Affiliate provider? ☐Yes ☐No | If "Yes" was client offered 2 or more other referrals? ☐Yes ☐No

REFERRALS

Client Referred Beyond EAP to: (Check all below that apply, be sure to include cases where client is continuing with affiliate)

☐ Behavioral Health Outpatient
☐ Behavioral Health Partial Hospital
☐ Behavioral Health Inpatient
☐ Alcohol/Drugs Outpatient
☐ Alcohol/Drugs Partial Hospital/Intensive
☐ Alcohol/Drugs Inpatient/Residential
☐ Emergency Services
☐ Medical
☐ Legal Services FEI
☐ Legal Services Non-FEI
☐ Financial Services FEI
☐ Financial Services Non-FEI
☐ Work-Life Services FEI
☐ Work-Life Services Non-FEI
☐ Internal Company EAP
☐ Self-Help
☐ Other

Payment category for Referral(s) (check all that apply): ☐ Employee's Company Medical Insurance ☐ Self- Pay ☐ Other Insurance ☐ No Cost/Low Cost Assistance. | Client Agreed to Plan ☐ Yes ☐ No

AFFILIATE ASSESSMENT OF CLIENT'S PROGRESS AS OF FINAL SESSION

Primary Presented Problem:	☐ Substantially Resolved	☐ Improved	☐ No Change	☐ Worse
Secondary Presented Problem:	☐ Substantially Resolved	☐ Improved	☐ No Change	☐ Worse
Affiliate-Assessed Additional Problem:	☐ Substantially Resolved	☐ Improved	☐ No Change	☐ Worse

AFFILIATE FOLLOW-UP (Include clients who continue with affiliate beyond EAP)

Date of direct follow-up with client. _____/_____/_____

Did client follow up on referral plan? ☐ Yes ☐ No

CERTIFICATION

I/We certify that all information on this form is accurate and complete.

_____ _____
Clinician Signature Date

_____ _____
EAP Coordinator Signature Date