EAP CASE RECORD FORM

INSTRUCTIONS: Please obtain during the initial assessment and retain in your record the client's signatures for the **Statement of Understanding** and **Consent to Release Information**. This form is used for billing. Complete the form in its entirety. Incomplete forms will be returned. ***Please do not include previously submitted dates of service.***

CONFIDENTIAL CONTACT HISTORY

Client Name:	**Client SSN: / /**
Employee Name:	**Employee SSN: / /**
Client Date of Birth: / /	**Client Phone Number: ( )**
Client is: ❑ **Employee** ❑ **Spouse/Significant Other** ❑ **Dependent Child**	**Company/Division/Location**
Provider Name	**Provider Billing Address**
Group Organization Name	**City/ State/ ZIP**
Tax ID Number or EIN:	**Authorization Number:**
Provider Signature:	**Date:**

SERVICE HISTORY **TREATMENT INFORMATION**

Date of Service	Billed Amount	Hrs	Type Code	With Whom	Client Engaged*	Symptom Resolution*	Work Effect Minimized*	Treatment Goal Progress*	Current GAF
/ /									
/ /									
/ /									
/ /									
/ /									
/ /									
/ /									
/ /									

Assessed Problem: ______________ **Case Status** _____ **Case Referral Type:** _____

Diagnosis (DSM IV) Axis 1: ________ **Client Satisfied with Treatment** ☐ **Yes** ☐ **No** ☐ **N/A**

<u>Type Code</u>	<u>Case Status</u>	<u>Referral Type</u>	<u>Assessed Problem</u>	
11 In Person/ Office 99 In Person/ On-Site <u>**With Whom**</u> 01 Employee 02 Spouse/Child 03 Employee and Spouse/ Child	04 Open Case 05 Case Re-Opened 06 Closed/No Referral 07 Closed/Client Discontinued 08 Closed/Refer Treatment 09 Closed/Refer Other Assistance 10 Closed/Continued through Insurance 11 Closed/Client Self – Pay	12 Psychiatrist 13 Counselor 14 IP Psychiatric 15 IP Medical 16 IP Substance Abuse 18 OP Medical 19 OP Substance Abuse 24 Self- Help Group 27 Community Resource	40 Alcohol/Drug Abuse 41 Alcohol/Drug Abuse Family member 42 Addiction – Other 43 Stress 44 Depression 45 Anxiety 46 Bereavement 47 Anger	48 Other Mental Health 49 Work-Related 50 Violence – Abuse 51 Marital Relationship 52 Family Issues 53 Children – Behavioral 54 Medical 55 WorkLife 56 Other

<u>***Rate of Client Engagement, Reduction of Symptoms, Rate of Affect upon Work Performance and Treatment Goals –**</u>
Use the Likert Scale Below: - Insert N/A if Not Applicable as part of the treatment

1 – No Improvement/Progress/Engagement	2 – Minor	3 – Moderate	4 – Good	5 – Complete

CONFIDENTIAL SERVICE PLAN & STATEMENT OF UNDERSTANDING

INSTRUCTIONS: Complete at end of assessment. Explain plan and Statement of Understanding to client and sign as witness. Client completes bottom section and signs form. Supply client copy, and mail original to MHNet.

STATEMENT OF UNDERSTANDING:

1. **Extent of EAP Services**. The EAP offers assessment, consultation, and short-term counseling for your personal concerns. Often short-term counseling is completed within the allotted EAP sessions. However, the number of required sessions is determined by your counselor. If, after the initial assessment, the EAP counselor determines that long-term counseling is necessary, you will be referred out of the EAP.
2. **Cost**. There are no charges to you or your family for using the EAP services. There may be charges, however, should you be referred to – and choose to utilize – the services of the professional resources. If an outside referral is chosen, every effort will be made to find the best resource at the lowest cost to you. Certain costs may be partially offset by your Medical Benefit Plan. Contact your carrier for plan benefits and exclusions.
3. **Confidentiality**. All records kept by the EAP will be treated confidentially. No information can be released outside the EAP without your written consent, unless required by law. Various laws require that the EAP staff assume the responsibility for reporting to appropriate parties instances when a person is a danger to themselves, to others, or when child abuse/neglect is involved.
4. **Supervisory Referrals**. A) Recommended Referrals – If a supervisor recommends that you contact the EAP (for instance, because of a performance problem), the supervisor will not be informed of your participation without your signed consent.
   B) Mandatory Referrals – The handling of mandatory referrals is in accordance with your employer's policies.
5. **Complaints**. If you have a complaint concerning any person associated with the EAP service, the quality of services provided, or any other aspect of the EAP, you may register the complaint with the 24 hour EAP Hotline by calling 1-800-492-4357.

5\. **Signature**. I have read this statement and may receive a copy.

Client/Guardian Signature ____ Date ________________

EAP Counselor Signature ____ Date ________________

Client Agreement to Consent to Release Information: I authorize the release of information to my Primary Care Physician (PCP). Information may be shared with them in order to inform and coordinate treatment.

☐Accept ☐Decline Client/Guardian Signature ______________________________________

PCP Name: ____________________________________ Phone Number: ___________________________

Note to Recipient: This confidential information is being disclosed to you from records that may be protected by Federal law and regulation found at USC 290dd-2 and 42CFR Part 2,dealing with confidentiality of alcohol and drug abuse patient records, as well as State law dealing with mental illness. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is permitted by written consent of the person to whom it pertains or as otherwise permitted under 42 CFR Part 2. State law may require the same. It is provided to you as the Primary Care Physician for the above named client solely for continuity of care puposes and to inform you of your patients health status. Violation of this Federal law or regulation is a crime and suspected violations may be reported to appropriate authorities in accordance with Federal regulation. Federal law and regulations do not protect any information about a crime committed by a patient or information about any threat to commit a crime, nor do they protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. The Federal rules restrict any use of this inforamtion to investigate or prosecute any alcohol or drug abuse patient.

Mail To: **MHNet** **P.O. Box 7802** **London, KY 40742**	**For questions regarding the EAP Program, client benefits or the Authorization please contact the MHNet EAP Division at** **(800) 492-4357** **For Questions regarding claims payment please contact MHNet Claims Service Now! at (866) 992-5246.**