# ALLONE HEALTH SAP BILLING FORM

## For the following client (use a separate form for each client):

**Client Name** _____

**Case #** _____

**Date of Initial Evaluation:** _____ **Flat Rate for SAP Evaluation:** **$ 250 per case**

**PROVIDER INFORMATION:** (please choose only **ONE** to prevent a delay in reimbursement)

**Tax ID #:** __ __ - __ __ __ __ __ __ __ __ __ **OR** **Social Security #:** __ __ __ - __ __ - __ __ __ __

**Name Associated with Tax ID #:**

_____

**Name Associated with SS#:**

_____

Please submit this Billing Form, after the initial evaluation and ***within 60 days of the initial date of service***, via **fax: (508-655-9922)** or mail:

**AllOne Health**
**Billing Department**
**190 North Main Street**
**Natick MA 01760**

SAP Evaluation is defined as: Initial Evaluation, Case Management and Follow-up Evaluation.
**Cancellations and no-shows will not be reimbursed, and no co-pay shall be charged the client.**
**Billing Forms received more than 60 days after the date of service will not be paid.**
If you have any questions please do no hesitate to call us at 800-492-0052 and follow the prompts.

**INSTRUCTIONS FOR SAP DOT CASES:**

- Conduct initial evaluation and write initial report following all DOT required information as described in the U.S. DOT SAP Guidelines: http://www.dot.gov/ost/dapc/testingpubs/SAP%20Guide%20Aug09.pdf.
- Fax the initial evaluation to your AllOne Health Resources SAP case manager at **508-655-9922** for review.
- After reviewed by AOH SAP case manager, mail the original initial report to the DER.
- Contact the treatment/education provider and regularly monitor the employee's compliance with SAP recommendation.
- Conduct a follow-up evaluation, write the follow-up report, and notify your AllOne Health Resources case manager once the follow-up evaluation is completed.
- Fax the follow-up evaluation report to your AllOne Health Resources SAP case manager at **508-655-9922**.
- Mail the follow-up report to the DER.

**INSTRUCTIONS FOR SAP NON-DOT CASES:**

- Non-DOT cases are usually handled in the same way as DOT cases.
- Be sure to check with an AllOne Health representative if you have questions.

ALLONE HEALTH RESOURCES

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# SUBSTANCE ABUSE EVALUATION
## For Department of Transportation workers

## Statement of Purpose

You have requested to have your substance use evaluated by a Substance Abuse Professional (SAP). Since you are an employee covered by the U.S. Department of Transportation regulations, the Substance Abuse Professional is required to follow DOT mandated procedures as indicated

The role of the Substance Abuse Professional is:

- To evaluate the extent of your use of alcohol and other drugs.
- To recommend the type of treatment (if any) that is most appropriate.
- To help you gain access to recommended treatment.
- To monitor your participation and compliance in the recommended treatment plan.
- To determine when you are appropriately ready to take a return-to-duty alcohol or other drug test.
- To recommend the frequency and type of follow-up tests.

This evaluation is not drug or alcohol treatment, but rather an assessment to determine what type of treatment/education you require. When the assessment has been completed, your Substance Abuse Professional will recommend that you receive treatment or education to assist you. Responsibility for payment to the referral source is yours.

Your Substance Abuse Professional will report back to your Designated Employer Representative (DER) the information described on the Statement of Understanding form. Some additional information, however, cannot remain confidential: when individuals appear to be in danger of harming themselves or others, the Substance Abuse Professional may be required to take action to assure the health and the safety of all concerned. In addition, the SAP is mandated by law to report to the appropriate state authorities situations where there is a reasonable cause to suspect child and/or elder abuse and/or neglect.

If at any time you have questions or concerns about your evaluation, you are encouraged to discuss the matter immediately with your Substance Abuse Professional. Once you have completed the SAP evaluation, the DOT forbids you from transferring to a different SAP, or from seeking another SAP opinion.

Client's Signature: _____ Date: _____

SAP's Signature: _____ Date: _____

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190 N. MAIN STREET | NATICK, MA 01760-2057 | TEL: 1.800.492.0052 | FAX: 508.655.9922 | WWW.ALLONEHEALTH.COM

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# STATEMENT OF UNDERSTANDING

**For the release and exchange of necessary information**

I, _____ acknowledge that _____,
(Name of client) (Name of Substance Abuse Counselor)

and the service agents and/or entities named below, must disclose to each other and receive from each other pertinent and relevant information regarding:

1. My violation of company regulations (prohibited conducts)
2. My drug and/or alcohol test results
3. The SAP's synopsis of my treatment
4. The SAP's assessment evaluation and treatment plan
5. Diagnostic information, where applicable
6. Treatment progress reports
7. Program completion information, including discharge summary, if applicable
8. Program involvement dates, attendance reports
9. Other relevant information as it pertains to my return-to-duty process

| | | | |
|---|---|---|---|
| ☐ **Treatment Provider** | _____ (Name) | _____ (Client's signature) | |
| ☐ **Employer** | _____ (Name) | _____ (Client's signature) | |
| ☐ **Managed Care** | _____ (Name) | _____ (Client's signature) | |
| ☐ **Other** | _____ (Name) | _____ (Client's signature) | |

This consent shall terminate one year from today, unless client chooses to revoke consent in writing at an earlier date.

_____ _____
Client's Signature Date

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# CLOSURE FORM

**CASE #:** _____ _____ **COUNSELOR:** _____

**CLIENT'S NAME:** _____ **DATE:** _____

**P. PROBLEM ASSESSED (#1)**

1. Alcohol
2. Other Drugs
3. Other Addictions
4. Substance Abuse/Family
5. Eating Disorder
6. Interpersonal
7. Depression
8. Anxiety
9. Grief
10. Couples
11. Family/Teenager
12. Family/Other
13. Domestic Violence
14. Elder Care
15. Child Care
16. Legal
17. Financial
18. Medical
19. Job Stress
20. Sexual Harassment
21. Career Issues
22. Layoff
23. Threat of Violence
25. Management Consult - Formal
26. Management Consult - Other
27. Not Available/Applicable
28. Trauma At The Workplace

**S. SUBSTANCE ABUSE INFORMATION**

1. Substance Abuse/Self
2. Substance Abuse/Other
3. ACOA
4. SA/Self & Other
5. Not Applicable
6. Eating Disorder
7. Other Addictions
8. Not Available/Applicable

**T. OCCUPATIONAL STATUS**

1. Supervisor only reports job impairment
2. Employee only report job impairment
3. Both report job impairment
4. No impairment
5. No information
6. Not applicable (family member)

**U. NATURE OF PERFORMANCE PROBLEM**

1. Absent
2. Tardy
3. Productivity
4. Quality
5. Accidents
6. Disruption
7. Relationships
8. Concentration
9. Positive Drug Test
10. Substance Abuse/Work
11. Other
12. Not Applicable

**V. IMPROVEMENT IN JOB PERFORMANCE**

1. None
2. Mild
3. Moderate
4. Significant
5. Not Available

**W. TREATMENT AT EAP**

1. No Show
2. Management Consultation
3. Debriefing
4. Assessment Brief/Tx
5. Assessment/Referral
6. Telephone Info Only
7. Dependent Care
8. Assessment Not Completed
9. Not Available/Applicable

**X. NUMBER OF SESSIONS**

1. No Show
2. 1
3. 2
4. 3
5. 4
6. 5
7. 6+
8. Telephone Only
9. Not Available

**Y. REFERRAL INFORMATION**

1. Substance Abuse in-patient
2. SA day/evening tx
3. SA out-patient
4. SA out-patient & self-help
5. MH in-patient
6. MH out-patient
7. Self-Help Only
8. Medical
9. Legal
10. Financial
11. Vocational
12. Child Care
13. Elder Care
14. Other
15. No Referral
16. Not Available

**Z. REFERRAL ACCEPTED**

1. Yes
2. No
3. Not Available/Applicable

**CC. IMPROVEMENT IN FUNCTIONING**

1. Yes
2. No
3. Not Available/Applicable

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