ALLONE[SM] HEALTH RESOURCES

GUIDELINES FOR
ALLONE HEALTH EAP AFFILIATE STAFF

RESPONSIVENESS:

- Please respond to calls from AOH within one business day
- Contact client within 24 hours of receiving the case to offer an appointment within one week

COMMUNICATION: Inform AOH in case of the following:

- Client no shows or fails to respond to contact attempts
- For any complicated, high-risk situation

DOCUMENTATION: For each referral please use the following AOH forms:

- Statement of Understanding (signed by client and filed with client's record that you hold)
- Closure form (to be submitted within 30 days of termination)
- Release of Information (when referring case)
- Billing Form (to be submitted within 60 days of the first day ct was seen)

REFERRALS: The session model will be provided at the time of referral. Depending on company's contract, self-referral may be allowed. If referring to another provider, ask client to sign a Release of Information to allow communication with new provider. (Expenses associated with any referrals are the responsibility of the client.)

FORMAL SUPERVISORY REFERRALS: A formal referral, initiated by a supervisor due to job performance, will be communicated at the time of referral. Client involvement is voluntary and confidential and no information is communicated to the employer without client consent. Once client has signed the Authorization to Inform Employer form, HREAP will only communicate to the employer client's attendance and cooperation. Your contact will be an HREAP Account Manager, and under no circumstances are you to communicate with the client's supervisor or employer. Additional affiliate responsibilities:

- Case collaboration with assigned AOH Account Manager
- Ask client to sign the Authorization to Inform Employer form
- Monitor compliance for up to one year

BILLING PROCEDURES:

- Client makes no payment.
- Please submit Provider Bill for Services within 60 days of the date of service.
- Reimbursement for services shall generally be made within forty-five days (45) days from date of receipt of correct and complete invoice; provided, however, **no reimbursement** for services shall be made if an invoice for such services is not received by AOH EAP within sixty (60) days from the date of rendering of such services by Subcontractor.
- There is no payment for no-shows or late cancellations. As our client companies have contracted for no-cost counseling for their employees and household members, it is not possible to bill clients directly for missed appointments.

12-A003NT 9/11

STATEMENT OF UNDERSTANDING

AllOne Health EAP offers assessment, short-term counseling, referral, and follow-up services for you and /or your family/household members.

All EAP assessment and referral services are provided at no cost to you or your family/household members. If a referral is made outside the EAP, the financial responsibility for payment to the referral source is yours. Although we endeavor to provide you with high quality referrals, we do not assume any responsibility for the services that may ultimately be provided by these referrals.

The information you share with your counselor is confidential. The EAP will not release information to anyone, including your employer or family/household member, without your written consent. However, counselors are mandated reporters, which mean they are required by law to report to the appropriate state authorities situations where there is a reasonable cause to suspect child and/or elder abuse. In addition, if an individual expresses intent to harm self or others, the counselor is required to break confidentiality to assure the health and safety of all concerned. There are occasions, in keeping with standard clinical practice; when clinical information may be shared between AllOne Health EAP staff members.

If at any time you have any concerns or questions about the services you receive through AllOne Health EAP, you are encouraged to discuss the matter immediately with your counselor and/or with an AllOne Health EAP clinical staff member at 800-451-1834.

IT IS VERY IMPORTANT THAT IF YOU CANNOT KEEP YOUR SCHEDULED APPOINTMENT, YOU GIVE YOUR COUNSELOR A 24-HOUR CANCELLATION NOTICE.

Name of Client:____

Client Signature: ____________________________________ Date: __________

Signature of Counselor:________________________________ Date: __________

Client's Case #:____

12-A003NT 9/11

ALLONE[SM]
HEALTH RESOURCES

AUTHORIZATION TO INFORM EMPLOYER

I understand that my employer recommended that I contact the Employee Assistance Program (EAP) and that my employer is requesting certain information. I authorize the EAP to inform my employer of the following (the EAP checks all that apply):

( ) Whether or not I complete an initial session with an EAP counselor

( ) Whether or not I am complying with the EAP counselor's recommendations

( ) Other: ____

____

I, ___________________________________, grant authorization for the EAP to disclose the information selected above to the following employer representative(s):

____
Employer Representative

This permission will expire one year from today or upon written request.

_________________________________ Employee Signature

_____________________________ Counselor Signature

________________________ Date

________________________ Date

Note:

The EAP does not release information without a client's written consent. However, some information cannot remain confidential. When individuals express intention to harm themselves or others, the counselor may be required to break confidentiality to assure safety of all concerned. In addition, there are laws that require counselors to report child and elder abuse and neglect to appropriate state authorities, and to comply with court orders to release records.

12-A003NT 9/11

ALLONE[SM] HEALTH RESOURCES

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

12-A003NT 9/11

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

AllOne Health Resources EAP

190 North Main Street
Natick Massachusetts 01760
(phone) 800-492-0052
(fax) 508-655-9922

PROVIDER BILL FOR SERVICES

For the Month Of:______________________ Date Submitted:___________________________

If you bill under your SS# please complete this box: **OR** If you bill under your Tax ID# please complete this box:

Social Security #____________________	**TaxID#** ____________________
Provider Name: ____________________	Name Associated with Tax ID#: ____________________
Address: ____________________	Address: ____________________

Client Case #	Client Name	Date of Session	Total Hrs.
EX: 128-003-180-06-01	Doe, Jane	03/20/11	

HOURS FOR MONTH: __________ X RATE: _____________ = TOTAL DUE $ ___________________

Please remember that each provider bill should be submitted for the SAME MONTH and YEAR, (i.e., this bill would be for March 2011only.) Please put all cases for the month on this bill. If you have any questions regarding this form, please feel free to call our billing clerk at 800-492-0052 or 508-650-6861. Please note, reimbursement for services shall generally be made within forty-five (45) days from the date of receipt of correct and complete invoices. **BILLS RECEIVED MORE THAN 60 DAYS AFTER THE DAY THE SERVICE WAS PROVIDED WILL NOT BE PAID.**