GUIDELINES FOR TALK ONE-2-ONE AFFILIATE STAFF

RESPONSIVENESS:

- Please respond to calls from Talk One-2-One within one business day
- Contact client within 24 hours of receiving the case to offer an appointment within one week

COMMUNICATION: Inform Talk One-2-One in case of the following:

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

DOCUMENTATION: For each referral please use the following Talk One-2-One forms:

- Statement of Understanding (signed by client)
- 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 client was seen)

REFERRALS: The session model will be provided at the time of referral. Depending on company's contract, self-referrals 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.)

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 (45) days from the 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 Talk One-2-One 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 students, it is not possible to bill clients directly for missed appointments.

Phone: 800.492.0052 | Fax: 508.655.9922
www.studenttalkone2one.com

TALK ONE-2-ONE STUDENT ASSISTANCE PROGRAM

STATEMENT OF UNDERSTANDING

AllOne Health's **Talk One-2-One** student assistance program offers assessment, short-term education, referral, and follow-up services for you.

All Talk One-2-One assessment and referral services are provided at no cost to you. If a referral is made outside of Talk One-2-One, 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. Talk One-2-One will not release information to anyone, including your college or family/household member, without your written consent. However, counselors are mandated reporters. 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 with Talk One-2-One staff members.

If at any time you have any concerns or questions about the services you receive through your Talk One-2-One student assistance program, you are encouraged to discuss the matter immediately with your counselor and/or with a Talk One-2-One clinical staff member at 800-492-0052.

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 #:_____

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PROVIDER BILL FOR SERVICES

Mail: AllOne Health, 190 North Main Street, Natick MA 01760
Fax: 508.655.9922

talk one2one℠ ANY PROBLEM, ANYTIME, ANYWHERE.

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	1

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 2011 only.) 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 x3. Please note that 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.**

TALK ONE-2-ONE STUDENT ASSISTANCE PROGRAM CLOSURE FORM

talk one2one℠ ANY PROBLEM, ANYTIME, ANYWHERE.

CASE #: _____

COUNSELOR: _____

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

K. Problem Assessed Category

1. Career Consultation
2. Consult - Faculty/Staff
3. Consult – Fraternity Advisor
4. Elder/Child
5. Family/Couples
6. Legal/Financial/Medical
7. Mental Health
8. Post-Military Adjustment
9. School Related
10. Substance Abuse/Addictions

L. Problem Assessed

1. Academic Stress
2. Administrative (formal) Referral
3. Alcohol
4. Anger Management
5. Anxiety
6. Assault
7. Career Issues
8. Child Care
9. Consult - Faculty/Staff
10. Consult-Fraternity Advisor
11. Couples
12. Critical Incident on Campus
13. Depression
14. Domestic Violence
15. Eating Disorder
16. Elder Care
17. Family/Other
18. Family/Teenager
19. Financial
20. Gambling Addiction
21. Grief
22. Internet Addiction
23. Interpersonal
24. Learning Disability
25. Legal
26. Medical
27. Mental Health
28. Mentally Ill
29. Other Drugs
30. PTSD
31. Sexual Harassment
32. Smoking Addiction
33. Substance Abuse – Family
34. TBI – Traumatic Brain Injury
35. Threat of Violence
36. Trauma

M. Academic Status

1. Warning
2. Probation
3. Suspension
4. Expulsion
5. N/A

N. Academic Impairment

1. Attendance
2. Concentration
3. Disruption
4. Grades
5. Relationships
6. Substance Abuse
7. N/A

O. Improvement in Academic Performance

1. Yes
2. No
3. N/A

P. Treatment at Student Assistance Program

1. Assessment Brief/Tx
2. Assessment/Referral
3. Critical Incident on Campus
4. Faculty/Staff Consultation
5. Telephone Info Only
6. N/A

Q. Number of Face to Face Counseling Sessions

1. No Show
2. 1
3. 2
4. 3
5. 4
6. 4+
7. N/A

R. Number of Telephone Counseling Sessions

1. No Show
2. 1
3. 2
4. 3
5. 4
6. 4+
7. None Requested

S. Referral Information

1. Career
2. Child Care
3. Elder Care
4. Fearless Flying
5. Financial
6. Food
7. Housing
8. Legal
9. Medical
10. MH in-patient
11. MH out-patient
12. New Parent's Partner
13. SA day/evening Tx
14. SA out-patient
15. Self-Help
16. Substance Abuse in-patient
17. Utilities
18. N/A

T. Referral Accepted

1. Yes
2. No
3. N/A

U. Improvement in Functioning

1. Yes
2. No
3. N/A

V. Did the services help the student to stay in school?

1. Yes
2. No
3. N/A

ALLONE HEALTH RESOURCES

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www.studenttalkone2one.com

RELEASE OF INFORMATION CONSENT FORM

I, _____, hereby authorize the AllOne Health Resources, Talk One-2-One, Student Assistance Program to disclose/obtain specified information to/from:

_____

_____

_____

for the purpose of referral to a professional practitioner or agency or for the purpose of

_____

_____

_____

_____.

Such information includes:

_____ Psychological Assessment

_____ Personal, social or family history

_____ Medical Information

_____Other

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

Client Name (print): _____Date: _____

Client Signature: _____

Counselor Name (print): _____ Date: _____

Counselor Signature: _____

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