HDC
Human Development Company

Affiliate Provider Instructions & Client Paperwork

EAP Policies for Providers (pg 2)**:** Please review polices prior to meeting with the client.

Client Intake Form (pg 3)**:** Please ask client to fill out this form completely and legibly. Completed form must be submitted to HDC along with reimbursement form on all initial client billings. Reimbursement forms received without this form will be returned, delaying reimbursement and possibly resulting in late submission fee reductions.

Statement of Understanding (pg 4)**:** Must be signed and witnessed during client's initial session and returned to HDC with the Client Intake Form.

Patient Privacy Notice (pg 5): Must be signed during client's initial session and returned to HDC with the Client Intake Form.

Case Closure Form (pg 6): This form should be filled out upon completion of the EAP services. Please fill out the form completely and return to HDC with final invoice. If offering a referral to yourself or another member in your group, a Freedom of Choice Affidavit must be signed (see next guideline).

Freedom of Choice Affidavit (pg 7): This form must be signed by the client if offering a referral to yourself or anyone in your group. The form verifies that the client has been offered at least two other resources outside of your practice and within his/her insurance plan, but has elected to stay with you, independent of the EAP services.

Provider Reimbursement and Summary Form (pgs 8 & 9): Submit invoices to our office via fax (502-589-5545), secure email or through USPS. Any paperwork for a case received more than 60 days after the date of the earliest session will be subject to a fee reduction (please see the reimbursement form for late submission schedule). Legible copies of the case notes will be accepted in place of the summary form.

Special Situations

HDC requests that affiliates contact us in the following situations:

- The client threatens harm to self or others.
- Reportable situations child/elder abuse or neglect.
- Client taking legal action against employer. HDC does not provide advice or support for employees engaged in or contemplating legal action against their employer. As an HDC affiliate, you are expected to maintain strict therapeutic neutrality, especially on this issue. **Please do not advise clients to take legal action against their employer.**
- Client requests for the completion of FMLA or disability paperwork. Completion of FMLA forms are not part of the program we provide. **HDC does not make the determination if a client is fit to work.**
- Client request for records.
- If additional sessions are needed/requested.

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EAP Policies for Providers

- ☐ Clients, employers, and insurance carriers are not to be billed, or sent statements, for EAP Services!

- ☐ Clients from the same employer are not to be scheduled for back-to-back appointments. This is so confidentiality is maintained.

- ☐ EAP Providers should never communicate with employers. If you receive a request from an employer, please contact HDC immediately.

- ☐ EAP Providers should not write letters regarding an employee's ability to do his or her job and/or be off from work. If such request is received from the employee and/or a representative of the workplace, please contact HDC immediately

- ☐ EAP providers are not permitted to write letters or release information to courts, attorneys or agencies to support employee claims regarding time, disability, workers' compensation, custody or any other issues.

- ☐ The EAP does not provide disability evaluations.

- ☐ The EAP counseling sessions cannot be used as a substitute for court-ordered counseling of any kind. The employee may be seen by the EAP counselor while he/she is receiving court-ordered treatment but we are not a substitute for it, and may not write letters to the court on behalf of the client.

- ☐ EAP counselors are to be familiar with all confidential requirements regarding employee assistance programs, alcohol and drug abuse statutes, etc. No client information is to be revealed to anyone without the employee's written consent

- ☐ All substance abuse cases must be referred to a treatment resource immediately in addition to AA or NA meetings. AA and NA groups are not considered treatment.

Please contact our office at 502-589-4357 with any questions/concerns you may have.

HDC CLIENT INTAKE

HDC
Human Development Company

DATE: _____/_____/_____ **(PLEASE PRINT LEGIBLY)**

CLIENT FIRST NAME: _____ **(MI)** _____ **(LAST)** _____ **DOB:** ____/_____/_____

HOME MAILING ADDRESS: _____ **CITY:** _____ **STATE:** _____**ZIP:** _____

CELL PHONE: (_____) _____-_____ **OK to call? Y / N**

HOME PHONE: (_____)_____-_____ **OK to call? Y / N**

WORK PHONE: (_____)_____-_____ **OK to call? Y / N**

EMAIL ADDRESS: _____ **HAVE YOU UTILIZED OUR SERVICES BEFORE? Y / N**

EMPLOYEE FIRST NAME: _____ **(MI)** _____ **(LAST)** _____ **DOB:** _____/_____/_____

COMPANY NAME: _____ **JOB CATEGORY/TITLE:** _____

LENGTH of EMPLOYMENT: _____ **years/** _____**months**

THE FOLLOWING INFORMATION IS TO BE COMPLETED FOR/BY THE CLIENT:

GENDER

- ☐ Female
- ☐ Male

MARITAL STATUS

- ☐ Single
- ☐ Married

CASE OPEN ON

- ☐ Employee only
- ☐ Dependent

REFERRED TO EAP BY

- ☐ Self/Family/Peer
- ☐ Supervisor suggested
- ☐ ***Supervisor Formal****

Supervisor's Name:

_____

Supervisor's Number:

(___)_____

WORK PERFORMANCE PROBLEMS

- ☐ Absent
- ☐ Tardy
- ☐ Problems relating to others
- ☐ Workers comp case
- ☐ Alcohol/Drug or positive drug screen
- ☐ Family member
- ☐ No problems on the job

PERSONNEL ACTIONS TAKEN

- ☐ Verbal Warning
- ☐ Written Warning
- ☐ Suspension
- ☐ Termination
- ☐ N/A

JOB CATEGORY

- ☐ Employee/Staff
- ☐ Family member
- ☐ Faculty
- ☐ Retiree
- ☐ Resident physician

PROBLEM(s) PRESENTED BY CLIENT

- ☐ Alcohol/Drug
- ☐ Alcohol/Drug-related (family)
- ☐ Addictions - Other
- ☐ Anxiety
- ☐ Bereavement/Grief
- ☐ Depression
- ☐ Eating disorder
- ☐ Family
- ☐ Financial
- ☐ Legal
- ☐ Marital/Relationship
- ☐ Stress
- ☐ Trauma
- ☐ Work-related

HOW DID YOU HEAR ABOUT US?

- ☐ Posters
- ☐ Brochures
- ☐ Supervisor suggested
- ☐ Co-worker suggested
- ☐ Family suggested
- ☐ Training/Orientation
- ☐ Prior participation

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STATEMENT OF UNDERSTANDING

Please check the items below to acknowledge your consent:

- ❑ I am being seen for short-term counseling/coaching through my EAP. My EAP counselor/consultant will advise me if additional or long-term services are warranted and will refer me to an appropriate resource. I am financially responsible for any treatment program to which I may be referred.

- ❑ I understand that I have a right to privacy and to review, request, and/or provide an addendum to information in my records.

- ❑ I am not permitted to bring weapons of any kind on the premises.

- ❑ The only exceptions to confidentiality are in life threatening situations or those involving abuse or neglect, or upon my written consent.

Court-related issues:

- ❑ I will not attempt to use my EAP participation for any related process, court proceeding or court-ordered treatment for anger management, substance abuse, custody issues or any other court-ordered treatment.

- ❑ The EAP cannot be used for litigation or advocate on my behalf and will not write letters on my behalf or voluntarily release information to other counselors, courts, attorneys, schools or agencies to support claims regarding custody, leave time, suspension, disability, workers' compensation, or any other issue.

Excuses from work/school:

- ❑ EAP counselors do not have the authority to **excuse** clients from work/school. However, verification of appointments is available at the front desk.

_____	_____	_____
Signature	Print Name	Date

HDC EMPLOYEE ASSISTANCE PROVIDER

NOTICE: PATIENT PRIVACY

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your protected health information and to provide you with notice describing:

HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

- We are not required by law to have your written authorization disclose your protected health information to provide, coordinate, or manage your counseling and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose information about your current therapy to a drug and alcohol treatment center if you are referred to them for more extended care under the case management of the EAP.

- We may be required or permitted by certain laws to use and disclose your protected health information for other purposes without your consent or authorization. These possible situations include: Court Order/Subpoena, Child/Adult Abuse/Neglect, Deemed a Threat to Self or Others, Commission/Threat of a Crime, or Other Situations Required by Law.

- As our client, you have the rights relating to inspecting and copying your protected health information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your protected health information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and filing a complaint if you think your rights have been violated.

- We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE and our privacy practices and procedures from time to time. The Effective Date at the bottom left hand side of this page indicates the date of the most current NOTICE in effect.

- You have the right to receive a copy of our most current NOTICE in effect. Please contact our office at 502-589-4357 or info@humandev.com to request a copy.

- If you have any questions, concerns or complaints about the NOTICE or your protected health information, please contact Daniel Lee, the Privacy Officer, at 502-589-4357 or 800-877-8332.

_____ _____

CLIENT SIGNATURE **DATE SIGNED**

My signature verifies that I have read and understand the above HIPAA Compliance information.

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Human Development Company

Case Closure Form

Client Name: _____ Employer: _____

Closing Notes:

_____

_____

_____

☐ **Assessed Problem:**

A. Alcohol	**F**. Financial	**K**. Job/Career	**P.** Eating/Weight
B. Polydrug	**G**. Gambling	**L**. Legal	
C. Codependency	**H**. Child	**M**. Medical	
D. Other Drug Abuse	**I**. Job/Career	**N**. Non-EAP	
E. Eldercare	**J**. Marital/Family	**O**. Psych/Emotional	

☐ **Client Action:**

A. Declined Help **B**. Affiliate Visit ONLY **C**. Affiliate and Referral

☐ **Treatment**:

A. CD Inpt Rehab	**E**. Gambling	**I**. Non-EAP	**M**. Unneeded
B. Detox	**F**. Job/Career	**J**. Psych Inpatient	**N**. Self-Help
C. CD Intensive Outpatient	**G**. Legal	**K**. Outpatient (non-CD)	
D. CD Outpatient Counseling	**H**. Medical	**L**. Community Services	

Referred To: _____

Address: _____

City, State, Zip: _____ **Phone**: _____

☐ **Disposition**:

A. Resolved	**D**. Worsened	**G**. Retired	**J**. Non-EAP
B. Improved	**E**. Client Dropped Out	**H**. Laid Off	
C. Unimproved	**F**. Employer Terminated	**I**. Deceased	

Counselor's Signature & Credentials: _____ **Date:**_____

FREEDOM OF CHOICE AFFIDAVIT

MUST BE SIGNED BY A CLIENT CONTINUING IN TREATMENT WITH ASSESSING PROVIDER **AFTER EAP SERVICES ARE COMPLETED**.

I, _____, verify that after my consultation with _____
Client Name Provider Name

of _____, located in _____, _____, an affiliate of the
Agency Name City State

Human Development Company EAP, I have freely decided to enter long-term treatment with this EAP affiliate.

- I understand that EAP benefit is for assessment, short-term counseling and referral services only.
- I further understand that based upon my assessment by the HDC/SAI affiliate, I have been referred for long-term treatment.
- I verity that I have been offered a referral to **at least two** other long-term treatment resource besides the EAP affiliate. I have instead decided to seek ongoing assistance with the EAP affiliate as a private practitioner.
- I understand that these long-term counseling sessions are no longer considered EAP visits.
- **I also understand that HDC EAP will no longer pay or be responsible for the services provided by this therapist as I have freely chosen to enter into a direct payment relationship with him/her.**
- **I further understand that I am solely responsible for determining if the services of this therapist are covered under my medical insurance plan.**

_____ _____
Client's Signature Date

_____ _____
Clinician's Signature/Witness Date

PROVIDER: Please list the alternate treatment option(s) below. This provider must be outside of your practice and not affiliated with any individual, group, or treatment facility in which you have financial interest.

_____ _____
Providers Name/Clinic **Phone Number**

_____ _____
Providers Name/Clinic **Phone Number**

HDC EMPLOYEE ASSISTANCE PROVIDER
502-589-4357/800-877-8332

HDC EMPLOYEE ASSISTANCE PROGRAM

PROVIDER REIMBURSEMENT FORM

Make Payable To:

EAP Group/Affiliate Name _____ **Tax I.D.#/SS#** _____

Billing Address _____

City _____ **State** _____ **Zip** _____

Phone Number **Fax Number** **Email Address**

Activity Codes:

AS - Assessment **BT - Brief Therapy** **TR - Training**
CID - Debriefing **TV - Travel** **NS - No Show (No Payment)**

BILLABLE SERVICES

One Client per Billing Sheet

Service Date	Client Name	Employee Name	Company Name	Activity Code	Session Number	Session Rate	HDC ONLY

By submission of this request for reimbursement, the undersigned (Affiliate) warrants and represents that (s)he has performed the services identified above on the dates and for the times specified. Provider agrees that timeliness of submission of this form and associated service documentation required by HDC/SAI is essential to the performance of services by Affiliate, and so consents to the fee reductions specified below for late submission:

Number of days received After each service date	Fee Reduction	Net Fee
Between 61 and 90	25%	75%
Between 91 and 180	50%	50%
After 181 days	100%	0%

Affiliate agrees that (s)he shall not seek reimbursement for the above services from any payer other than HDC including the client and/or any insurer.

_____ _____

Affiliate Signature **Date**

Return To: **HDC, Attn: Billing Department**
1930 Bishop Lane, Suite 603
Louisville, KY 40218
502-589-4357
502-589-5545/FAX

HDC EMPLOYEE ASSISTANCE PROGRAM

PROVIDER SUMMARY FORM
Session/Training/CID

Date of Service _____ **Client/Company Name** _____

Number of Sessions _____ **Number of Participants** _____

Summary:

_____

_____

_____

_____

_____

_____

_____

_____

Comments:

_____

_____

_____

Recommendations:

_____

_____

_____

_____ _____

Affiliate Provider Signature **Date**

Return To: **HDC, Attn: Billing Department**
1930 Bishop Lane, Suite 603
Louisville, KY 40218
502-589-4357
502-589-5545/FAX