EAP Initial Assessment

### Initial Appointment
- [ ] Kept
- [ ] Cancel/failed, no reschedule
- [ ] Second appointment failed
- [ ] Statement of understanding signed
- [ ] Notice of privacy practices given

### Client Presenting Problem
- [ ] Alcohol
- [ ] Drugs
- [ ] Sexual Assault
- [ ] Compulsive Gambling
- [ ] Eating Disorder
- [ ] Psych. Emotional/Family
- [ ] Stress
- [ ] Legal
- [ ] Psych/Emotional
- [ ] Work Related Issues
- [ ] Alcohol/Drugs Family
- [ ] Incest/Child Sexual Abuse
- [ ] Medical
- [ ] Financial
- [ ] Elder Care
- [ ] Child Physical Abuse
- [ ] Grief/Loss
- [ ] Education/Occupational
- [ ] Polydrug
- [ ] Job Stress
- [ ] Gambling/Family
- [ ] Domestic Violence
- [ ] Divorce/Separation
- [ ] Relationship (Marital, Family)

### Psychosocial Assessment
Concerns exist in following issue areas:
- [ ] Family/Relationship
- [ ] Medical
- [ ] Parent/child
- [ ] Elder Care
- [ ] Occupational
- [ ] Domestic Violence
- [ ] Financial
- [ ] Legal
- [ ] Significant Losses
- [ ] Lack of Supports
- [ ] Other

Comments Related to the above:

### Drug/Alcohol Assessment
- Current Use and pattern:
  
- Withdrawal Symptoms:
  
- History of Attempts to control use:
  
- History of treatment:
  
- Related consequences of Drug/Alcohol abuse:
  - [ ] Job
  - [ ] Legal Problems/DUI
  - [ ] Marital/Family/Relationship
  - [ ] Health/Medical
  - [ ] Financial Problems
  - [ ] Health Problems

Comments Related to the above:

- [ ] User
- [ ] Abuser
- [ ] Dependent

### Risk/Safety Assessment
- [ ] Suicidal
- [ ] History of attempts
- [ ] Current plan
- [ ] Weapons
- [ ] Homicidal
- [ ] Impulse control problems
- [ ] Self-Destructive or self-injury
- [ ] Psychosis or thought disorder

Current Prescription Medications and Reasons: (including length of time taken and dosage)

### Mental Health
- Treatment History:
  
- Comments related to Mental Health:
  
- Clinical Impressions:
  
### Level of Care Recommendations
- [ ] Short-term EAP Problem Resolution (only)
- [ ] Outpatient Psychotherapy (individual, family, marital) using health insurance benefits
- [ ] Psychiatric Referral
- [ ] Refer for evaluation for higher level treatment (IOP, Partial Hospital, or Inpatient)

Name(s) of Provider(s) or facility to which you referred client(s):

### Affiliate Counselor's Signature: ____________________________  Date: ________________
Client Assessment Summary and Case Closing Form

<table>
<thead>
<tr>
<th>Perspectives File #:</th>
<th>Affiliate Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s Last Name</td>
<td>Client First Name</td>
</tr>
</tbody>
</table>

### EAP Assessed Problem 1

- **Alcohol**
- **Drugs**
- **Sexual Assault**
- **Compulsive Gambling**
- **Eating Disorder**
- **Psych. Emotional/Family**
- **Incest/Child Sexual Abuse**
- **Education/Occupational**
- **Medical**
- **Financial**
- **Elder Care**
- **Child Physical Abuse**
- **Grief/Loss**
- **Alcohol/Drugs Family**
- **Gambling/Family**
- **Domestic Violence**
- **Divorce/Separation**

### EAP Assessed Problem 2

- **Alcohol**
- **Drugs**
- **Sexual Assault**
- **Compulsive Gambling**
- **Eating Disorder**
- **Psych. Emotional/Family**
- **Incest/Child Sexual Abuse**
- **Education/Occupational**
- **Medical**
- **Financial**
- **Elder Care**
- **Child Physical Abuse**
- **Grief/Loss**
- **Alcohol/Drugs Family**
- **Gambling/Family**
- **Domestic Violence**
- **Divorce/Separation**

### Primary Referral

- **Outpatient Psychiatric**
- **Inpatient Psychiatric**
- **Inpatient Alcohol/Drug**
- **Community Mental Health**
- **Medication Management**
- **Education – Substance Abuse**
- **Education – Mental Health**
- **Intensive Outpatient Alcohol/Drug**
- **Psychiatric Day Hospital**
- **Psych. Evaluation**
- **Medical**
- **EAP**
- **Self Help Group**
- **Financial**

### Secondary Referral

- **Outpatient Psychiatric**
- **Inpatient Psychiatric**
- **Inpatient Alcohol/Drug**
- **Community Mental Health**
- **Medication Management**
- **Education – Substance Abuse**
- **Education – Mental Health**
- **Intensive Outpatient Alcohol/Drug**
- **Psychiatric Day Hospital**
- **Psych. Evaluation**
- **Medical**
- **EAP**
- **Self Help Group**
- **Financial**

### EAP Outcome

- Problems resolved entirely within the EAP
- Referrals accepted using insurance
- Referrals accepted to community resources
- Client(s) did not complete EAP services

### Problem Outcome

- Resolved
- Improved
- Unchanged
- Unable to contact client

Affiliate Counselor’s Signature: ___________________________ Date: ________________
We appreciate your participation in the EAP/MAP and want to know how you felt about the program. Please take a moment to respond to each of the questions below.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you receive prompt and professional attention when you called the Employee/Member Assistance Program 800 Phone Number?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the EAP attempt to schedule your appointment within (3) three business days?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the scheduled location and time convenient to your work or home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the EAP/MAP counselor helpful in addressing your concern?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you recommend the EAP/MAP to someone else or use it again?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: __________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
Employee Assistance Program
Participant Statement of Understanding

To our EAP Participants:

Perspectives EAP is a voluntary service provided to you and your family as an employee benefit. Before we begin your assessment for services, there are several aspects of the program we would like to review.

Perspectives provides assessment, referral, follow-up, and depending upon the EAP model which your company has chosen, short-term counseling and/or case management. There is no cost to you for any EAP services provided by Perspectives. When a problem requires specialized or longer-term services, a referral may be made after the initial assessment. If you are referred, there may be fees involved for the specialized or longer-term services. Those services may be covered under the insurance benefits provided by your employer; however, it is your responsibility to determine whether the cost of those services is covered by your insurance benefits. It is your responsibility to verify your eligibility through your insurance vendor, which includes information around deductibles, lifetime maximum, and pre-existing conditions.

Sharing your personal information may be difficult and we want to assure you of our efforts to maintain your privacy. Perspectives EAP and/or its affiliate services are strictly confidential as mandated by state and federal laws. No information regarding the nature of the problem can be released without your expressed written consent. Lawful release of records is permitted for cases of child, elder or disabled adult abuse or if you pose a threat of imminent danger to yourself or others. Perspectives must also release records if court ordered or in instances where a lawsuit is filed against Perspectives.

If you need to cancel an EAP appointment, call your EAP counselor 24 hours prior to your scheduled time. If circumstances prevent this, please call your counselor to discuss the situation.

Should your supervisor or human resource representative initiate EAP services due to job performance concerns, neither the nature of the problem nor specifics about the recommendation will be disclosed unless you permit it with a written release of information. In instances where Perspectives is required to make a recommendation relative to your fitness to return to work, such a recommendation may be withheld if Perspectives is unable to fully disclose information due to not having your signed consent.

I have read and understand this Statement of Understanding.

__________________________________________  ________________
Signature of Client  Witness

__________________________________________  ____________________________
Printed Name of Client  Date
Notice of Privacy Practices

TWO PAGES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. You may obtain a copy of this policy and your privacy rights notice from your EAP counselor at any time upon request. We ask that you sign a copy of the statement of rights (next page).

Perspectives, and its affiliated network providers located in and outside of the United States, respect patient confidentiality and only release medical information about you in accordance with federal and state laws. This notice describes our policies related to the use of the records of your care generated by Perspectives, Ltd. If you have any questions about this policy or your rights contact Perspectives’ Privacy Officer.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your medical information with others beyond our practice, for purposes of:

Treatment: To provide, coordinate, or manage your care or any related services, including sharing information with others outside our practice that we are consulting with or referring you to.
Payment: To obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.
Healthcare Operations: To coordinate our business activities. This may include setting up your appointments, reviewing your care, and supervising our staff.

Information Disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Information may be shared to address the immediate emergency you are facing.
Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.
Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.
Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

PATIENT PRIVACY RIGHTS

You have the following rights under state and federal law:

Copy of Record. You are entitled to inspect the healthcare records our practice has generated about you. We may charge you a reasonable fee for copying and mailing your records.
Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.
Restriction on Record. You may ask us not to use or disclose part of the medical information. This request must be in writing. The Practice is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Perspectives’ Privacy Officer.
Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. We also will be glad to provide you information by email if you request it. If you wish us to communicate by email you are also entitled to a paper copy of this privacy notice.
Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact Perspectives’ Privacy Officer and ask for the Request to Amend Health Information form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement that you disagree with us. We will then file our response and your statement and our response will be added to your record.
Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your medical information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to Perspectives’ Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact Perspectives’ Privacy Officer in writing at our office further information. You also may complain to the Secretary of Health and Human Services if you believe our Practice has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. The Practice reserves the right to change its Privacy Policy based on the needs of the Practice and changes in state and federal law.

Acknowledgement of Privacy Rights and Consent for Disclosure of Protected Health Information between Affiliate Provider and Perspectives, Ltd.

I acknowledge receipt of and understanding of my privacy rights in connection with Employee (Member) Assistance Services. I further authorize Perspectives, Ltd. (Employee Assistance Program) and

(Affiliate and/or local organization providing EAP services on behalf of Perspectives)

to exchange written and verbal information about my (my family’s) employee assistance services including assessment information, needs, impressions, counseling recommendations, referrals, dates of service, and contact(s) with other parties in connection with treatment, payment, and EAP service operations.

______________________________
Signature(s) of adult client(s)

______________________________
Date

Perspectives’ Affiliate Provider will retain a copy of this notice with your signature in their records. A copy will also be provided to you upon request.