



EAP CASE ACTIVITY AND BILLING FORM

Instructions: Please print and complete ALL information. Please use ink.

Billing Type: Interim Final Re-Open

PAYER (the corporate client, employer, company/division, location or department through which EAP benefits are available)

Payer Name: _____

EAP PARTICIPANT DEMOGRAPHIC INFORMATION

Last Name(s): _____ First: _____ MI: _____ Participant Gender: Female Male
(Please also enter the participant name and employee Social Security Number in the appropriate area on the reverse side of this form)

Correspondence Address: _____ Participant DOB: ____/____/____

City: _____ State: _____ ZIP: _____ Home Phone: () _____

Employee Name (if not participant): Last: _____ First: _____ Employee Social Security Number: _____ / _____ / _____

Employee Hire Date: ____/____/____ Statement of Understanding Signed Release of Information Signed

Participant Category: Self Spouse Dependent Sibling Parent Unmarried Partner Other

Learned About EAP: Word of Mouth Printed Materials Electronic Media Union Representative Training / Health Fair Company Representative

Method of Initial Contact: ValueOptions Staff Office ValueOptions EAP Affiliate Internal EAP On-Site EAP

Relationship Status: Never Married Married Separated Divorced Widowed Cohabiting

Referral Source: Self Union Co-worker Medical / MRO HR Internal EAP Wellness Program Treatment Provider Supervisor (Informal) Supervisor (Job Performance)

Ethnicity: African-American Native American Asian / Pacific Islander Caucasian Hispanic Multiracial Arab-American Other

BILLING INFORMATION (Please keep a copy for your records. Form should be submitted to the billing address as indicated on the EAP authorization letter for the participant.)

Date(s) of Service (MM/DD/YY):

Total Sessions Billed: _____ Number EAP Sessions Used at Case Closing: _____

EAP Clinician Name & Credentials: (please print) _____ EAP Clinician Signature: _____ Date: _____

EAP Clinician Billing Address: _____

Phone: () _____ SSN OR Tax ID: _____ NPI Number: _____

EMPLOYMENT DATA (Complete only if employee is participant.)

Employment Status: Full Time Part Time Terminated Medical Leave Retired Disciplinary Leave Laid Off Disability / WC Leave Other **Union Member:** Yes No

Job Title Category: Executive / Manager Professional Technical Sales Office / Clerical Craft Worker (skilled) Operative (semi-skilled) Laborer (unskilled) Service Worker

Job Dysfunction: None Minimal Moderate Significant- no job jeopardy Significant- job jeopardy

Job Problem: Absenteeism Fitness for Duty Safety Issue(s) Unpaid Leave(s) Tardiness Positive Drug Screen Productivity Issue(s) Co-Worker Relationship
 Supervisor Relationship Aberrant Behavior Work Performance None

Participant Last Name: _____ First: _____ Employee Social Security Number: _____ / _____ / _____

PRESENTING VS. ASSESSED PROBLEM From the list below, choose just one Presenting Problem (P) and one Assessed Problem (A)

Substance Abuse P A <input type="checkbox"/> <input type="checkbox"/> Alcohol <input type="checkbox"/> <input type="checkbox"/> Drug <input type="checkbox"/> <input type="checkbox"/> Mixed Alcohol and Drug Abuse	Emotional / Psychological P A <input type="checkbox"/> <input type="checkbox"/> Anxiety <input type="checkbox"/> <input type="checkbox"/> Depression <input type="checkbox"/> <input type="checkbox"/> Disability <input type="checkbox"/> <input type="checkbox"/> Eating Disorder <input type="checkbox"/> <input type="checkbox"/> Hyperactivity / Learning Problem <input type="checkbox"/> <input type="checkbox"/> Impulse Control Problem <input type="checkbox"/> <input type="checkbox"/> Thought Disorder	Psychosocial / Environmental P A <input type="checkbox"/> <input type="checkbox"/> Child Care <input type="checkbox"/> <input type="checkbox"/> Adult/Elder Care Problem <input type="checkbox"/> <input type="checkbox"/> Family Problems <input type="checkbox"/> <input type="checkbox"/> Financial <input type="checkbox"/> <input type="checkbox"/> Grief / Loss <input type="checkbox"/> <input type="checkbox"/> Job / Occupational <input type="checkbox"/> <input type="checkbox"/> Legal <input type="checkbox"/> <input type="checkbox"/> Marital / Relationship Issues <input type="checkbox"/> <input type="checkbox"/> Situational / Adjustment Concern	Medical P A <input type="checkbox"/> <input type="checkbox"/> Medical Problem
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RISK ASSESSMENT: Indicate participant's risk to self and others both at case opening and again at case closing (0=none; 1=mild, ideation only; 2=moderate, ideation with EITHER plan or history of attempts; 3=severe, ideation AND plan, with either intent or means)

	CASE OPENING	CASE CLOSING	Notes:
Member's risk to self:	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	
Member's risk to others:	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	

FUNCTIONAL ASSESSMENT: Indicate participant's level of impairment for each item at case opening (O) and again at case closing (C).
 0=no evidence of impairment; 1=mild impairment; 2=moderate impairment; 3=severe impairment.

	Case Opening	Case Closing
Mood Disturbances (Depression or Mania)	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Anxiety	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Psychosis / Hallucinations / Delusions	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Thinking / Cognition / Memory / Concentration Problems	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Impulsive / Reckless / Aggressive Behavior	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Activities of Daily Living Problems	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Weight Change Associated with a Behavioral Diagnosis	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Medical / Physical Condition	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Substance Abuse / Dependence	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Job / School Performance Problems	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Social Functioning / Relationship / Marital / Family Problems	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3
Legal Problems	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3	<input type="checkbox"/> - 0 <input type="checkbox"/> - 1 <input type="checkbox"/> - 2 <input type="checkbox"/> - 3

GOALS	Met	Partially Met	Not Met	No Change
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EAP / Psychiatric Treatment History Assessed: Y N **Notes:**

Substance Abuse Treatment History Assessed: Y N **Notes:**

Strengths, Skills, Aptitudes & Interests Assessed: Y N **Notes:**

Supports Assessed: Y N **Notes:**

Military History Assessed: Y N **Notes:**

CASE CLOSING

Problem Status at Case Closing

Problem Resolved
 Problem Partially Resolved
 Problem Getting Worse
 No Change in Problem Status
 Not Applicable

Case Disposition

Face-to-face assessment/no referral
 Face-to-face assessment/referral accepted
 Face-to-face assessment/referral declined
 EAP Participant did not keep initial appointment
 EAP Participant withdrew before completion of services

Referral Type

No referral beyond EAP

Substance Abuse Treatment

Detox only
 Inpatient
 Intensive Outpatient (IOP)
 Other

Psychiatric Treatment

Inpatient
 Partial Hospitalization
 Outpatient (non-MD)
 Outpatient (MD)
 Other

Medical Treatment
 Community Resource