PENN FOUNDATION EAP INSTRUCTIONS

1. Penn Foundation EAP will contact the local Affiliate with the following information:
   - Client Name and Phone Number
   - Presenting Problem
   - Number of EAP sessions that the client has available

2. The local Affiliate will call the client at the phone number given and set up an appointment.

3. The local Affiliate will call Penn Foundation EAP at (215) 257-6556 or (800) 616-9248 with the Day/Date/Time of the client's initial appointment.

4. Penn Foundation EAP will email or fax the following EAP paperwork to the local Affiliate:
   - Employee Data Sheet
   - Statement of Understanding
   - Permission to Follow-Up
   - Client Summary/Billing Sheet

5. The client will fill out the Employee Data Sheet, Statement of Understanding Form, and Permission to Follow-Up Form at the initial appointment.

6. Please return all the EAP paperwork via email, fax or mail to Penn Foundation EAP upon closure of the case. If billing on a session-by-session basis, send all initial paperwork with the first billing sheet. Penn Foundation EAP will not reimburse for any services until all paperwork is returned. All completed EAP paperwork must be submitted within **60 days** of the last face to face session in order to be considered for payment.

Penn Foundation EAP
P.O. Box 32
Sellersville, PA 18960
(800) 616-9248 or (215) 257-6556
FAX: (215) 257-6714

PENN FOUNDATION EMPLOYEE ASSISTANCE PROGRAM

Employee Data Sheet -- Client Opening Data

For Office Use Only

Company Code:__________ Location::__________ *Counselor:__________ *OPEN DATE:____/____/____

OPEN AS (Check one): 1 ___New A/R Case 2 ___Client Consult 3 ___Supervisor Consult

___Reopened Case (CHECK HERE) (if 2 or 3, just enter Name & Phone)

CASE WAS OPENED ON: 1___Employee Only 2 ___Employee & Family Member *3 ___Family Member Only 4 ___Other

---

PLEASE FILL IN THE INFORMATION BELOW ON THE EMPLOYEE WITH EAP BENEFITS.
This information will be kept completely confidential and is for our records only.

NAME (FIRST): ____________________ (LAST): ____________________

ADDRESS: ____________________ CITY: __________ STATE: _____ ZIP: _______

HOME PHONE: (____) __________ WORK PHONE: (____) __________ EMPLOYER: __________

DATE OF BIRTH: _____/_____/_____ AGE: _______ SOCIAL SECURITY NUMBER: _____–_____–_____

PLEASE CHECK ONE ANSWER IN EACH CATEGORY.

***EDUCATION**
1____ 8 grades or less
2____ 11 grades or less
3____ High School Diploma
4____ Some College
5____ College Graduate
6____ Advanced Degree
7____ Data Not Available

***RACE**
1____ White
2____ Black
3____ Hispanic
4____ Native American
5____ Asian or Other
6____ Data Not Available

***SEX**
1____ Male
2____ Female
3____ Data Not Available

***MARITAL STATUS**
1____ Single
2____ Married
3____ Divorced
4____ Separated
5____ Widowed
6____ Living w/Someone
7____ Data Not Available

***REFERRAL SOURCE**
1____ Supervisor Mandatory
2____ Supervisor recommended it
3____ Medical Dept. or Employee Health
4____ Self
5____ Co-worker
6____ Spouse
7____ Other
8____ Data Not Available

***OCCUPATIONAL STATUS**
1____ Hourly Employee
2____ Support Staff
3____ Clerical
4____ Sales/Marketing
5____ Manager/Supervisor
6____ Administrator
7____ Professional
8____ Does Not Apply

STATUS
1____ Full Time
2____ Part Time
3____ As needed
4____ Temporary
5____ Other
6____ N/A Family Member
7____ Data Not Available

LENGTH OF SERVICE
1____ Under 1 Year
2____ 1 - 3 Years
3____ 4 - 6 Years
4____ 7 - 9 Years
5____ 10 -15 Years
6____ 16 or More Years
7____ N/A Family Member
8____ Data Not Available

YOUR HOUSEHOLD INCOME
1____ 0 - 9,999
2____ 10,000 - 14,999
3____ 15,000 - 19,999
4____ 20,000 - 24,999
5____ 25,000 - 29,999
6____ 30,000 - 34,999
7____ 35,000 - 39,999
8____ 40,000 - 44,999
9____ 45,000 - and up

***BEEN TO EAP BEFORE**
1____ No
2____ Once
3____ Twice
4____ Three Times
5____ Four Times
6____ Five or More Times
7____ Data Not Available

HEARD ABOUT EAP THRU
1____ Brochure
2____ Newsletter
3____ Payroll Stuffer
4____ Company Orientation
5____ Training/Workshop
6____ Other
7____ Data Not Available

SHIFT
1____ Days
2____ Evenings
3____ Night
4____ Rotating
5____ Other
6____ N/A Family Member
7____ Data Not Available

OTHER FAMILY OR HOUSEHOLD MEMBERS: (NAME, AGE, RELATIONSHIP)

____

____

____

Penn Foundation Employee Assistance Program

STATEMENT OF UNDERSTANDING

Description of Services:
Penn Foundation Employee Assistance Program provides problem assessment, brief counseling, and referrals to community providers. Services are provided at no cost to you or your immediate family members. The maximum number of EAP visits is limited by contractual arrangement with your employer, and each visit will last approximately 50 minutes. Your EAP does not provide medical diagnosis, court-related services, or on-going counseling.

If specialized or on-going counseling is indicated, a referral will be made following the problem assessment. If a referral is advised, your EAP counselor will work with you to find an appropriate community resource. We find that it is in your best interest to make a referral at the earliest possible point in the EAP process so that you can start work with the appropriate treatment provider. If you are given referrals, you are responsible for final verification of insurance coverage and for any fees involved.

Confidentiality:
Penn Foundation Employee Assistance Program maintains the highest standards of program confidentiality possible under law. Your counselor will not share any information with any person outside of Penn Foundation EAP without your written permission, except as allowed by law, or in a situation deemed potentially life threatening.

Penn Foundation Employee Assistance Program policy states that if your employer has designated your job as a safety sensitive position, and upon completion of your EAP assessment, your EAP clinician has reason to believe that you pose a potential danger to your workplace should you perform your tasks, the clinician will notify your employer of that potential danger. Please initial here to acknowledge that you have read and understand this statement. _________ (Client initials constitute an acknowledgment of this policy, **not** a release of information.)

Cancellation of Appointments:
Please give Penn Foundation Employee Assistance Program at least 24-hour prior notice regarding cancellation of an appointment. Cancellation without 24-hour prior notice will be counted toward the maximum number of visits allowed under the EAP contract.

I HAVE READ THIS STATEMENT AND UNDERSTAND ITS CONTENTS. ANY AREAS OF CONCERN HAVE BEEN DISCUSSED WITH MY COUNSELOR. I HEREBY GIVE MY CONSENT TO RECEIVE TREATMENT BY CLINICAL STAFF MEMBER(S) OF THE PENN FOUNDATION EAP. THIS CONSENT IS VALID UNTIL RESCINDED IN WRITING BY ME.

Client's Printed Name: ______________________________

Client's Signature: __________________________________ Date: ______________________

Parent or Guardian (When Required): ____________________

EAP Representative: ________________________________

In order to protect your confidentiality, please list the phone number where we have your permission to contact you and circle whether this is your cell, home, or work number.

Phone Number: ____ **(Cell / Home / Work)**

PERMISSION TO FOLLOW-UP

At the Employee Assistance Program, we want to evaluate how well we respond to the needs of the employees who use our services. This information helps us to make any improvements necessary in order for our EAP to be the best it can be. We would appreciate your help by allowing us to contact you to see how well you were satisfied with our services.

NAME: (please print)________________________________

ADDRESS: ________________________________

____

____

__________ I give Penn Foundation EAP permission to mail me a follow-up survey.

__________ I do not wish to receive a follow-up survey.

Signature____________________________ Date___________________

****

(FOR OFFICE USE ONLY - PLEASE DO NOT WRITE BELOW)

Date Closed:____________________ Number: ____________________

PENN FOUNDATION EAP

CLIENT SUMMARY FORM

Presenting Problem: ____

____

____

____

____

____

Brief Case Summary: ____

____

____

____

____

Case Still Open _______ **Case Closed** _______ **Client Referred:** _______ **Yes** _______ **No**

Referral made to: ____

**** Presenting Problem and Case Summary needs to be completed for each billing.****

BILLING SHEET

SUBCONTRACTOR NAME: ____

SOCIAL SECURITY # ________________________ TAX ID# ____________________

ADDRESS: ____

________________________________ ZIP ______________

PHONE: ________________________________

CLIENT NAME: ________________________ CLIENT #: ________________ NEW ____ RE-OPEN ____

DATES OF SESSIONS

1. ________________________ _____ Hrs.
2. ________________________ _____ Hrs.
3. ________________________ _____ Hrs.
4. ________________________ _____ Hrs.
5. ________________________ _____ Hrs.
6. ________________________ _____ Hrs.

Total Hours ________ x $________ per hour = $________