

PENN FOUNDATION EAP INSTRUCTIONS FOR REFERRAL

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 email or 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. Affiliate will have the client complete these at the initial session:
 - Employee Data Sheet
 - Statement of Understanding
 - Permission to Follow-Up
 - Client Summary/Billing Sheet (Affiliate completes)
5. 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
Email: eap@pennfoundation.org**

PENN FOUNDATION EMPLOYEE ASSISTANCE PROGRAM (EAP)

Employee Data Sheet- Client Opening Data

All Information will be kept completely confidential and is for our records only

For Office Use Only:

Company Code: _____ Counselor _____ Open Date _____

Open As: ___ New A/R Case ___ Reopen Case ___ Client Consult ___ Supervisor Consult

Case Opened On: ___ Employee Only ___ Employee & Family Member ___ Family Member Only ___ Other

PLEASE FILL IN THE INFORMATION BELOW ON THE EMPLOYEE WITH THE EAP BENEFITS

Employee Name: _____ DOB _____ Sex M F
Last First

Client Name: _____ DOB _____ Sex M F
(If Not Employee) Last First

Address: _____ City: _____ State: _____ Zip: _____

Cell/Home/Work # (ok to leave message) _____ Social Security # _____

Employer _____ Email _____

CHECK ONE ANSWER IN EACH CATEGORY. INFORMATION IS BASED ON THE EMPLOYEE WITH THE BENEFITS

<p>Education: ___ 11grades or less/ GED ___ High School Diploma ___ Some College ___ College Graduate ___ Advanced Degree</p> <p>Race: ___ White ___ Black ___ Hispanic ___ Asian ___ Multiracial ___ Other: _____</p> <p>Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Living w/ Someone ___ Other</p>	<p>Occupational Status: ___ Hourly Employee ___ Support Staff ___ Clerical ___ Sales/Marketing ___ Manger/Supervisor ___ Administrator ___ Professional</p> <p>Status: ___ Full Time ___ Part Time ___ As Needed ___ Temporary ___ Other</p> <p>Length of Service: ___ Under 1 Year ___ 1-3 Years ___ 4-6 Years ___ 7-9 Years ___ 10-15 Years ___ 16 or More Years</p>	<p>Household Income: ___ 0-9,999 ___ 10,000- 14,999 ___ 15,000- 19,999 ___ 20,000-24,999 ___ 25,000-29,999 ___ 30,000-34,999 ___ 35,000-39,999 ___ 40,000-44,999 ___ 45,000- and up</p> <p>Shift: ___ Days ___ Evenings ___ Nights ___ Rotating ___ Weekend ___ Other</p> <p>Been to EAP: ___ No ___ Yes How many times? _____</p>	<p>Referral Source: ___ Supervisor Mandatory ___ Supervisor Recommended ___ Med Dept/Employee Health ___ Self ___ Co-worker ___ Spouse ___ Friend ___ Human Resources ___ Parent ___ Other: _____</p> <p>Heard About EAP: ___ Brochure ___ Newsletter/Poster ___ Company Orientation ___ Training/Workshop ___ Supervisor Notification ___ Human Resources ___ Co-Worker ___ Payroll Stuffer ___ Spouse ___ Other: _____</p>
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List of Everyone Living in the Household: Name/Relationship/Date of Birth:

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.****

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BILLING SHEET

SUBCONTRACTOR NAME: _____

SUBCONTRACTOR AGENCY: _____

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 = \$ _____