PENN FOUNDATION EAP
INSTRUCTIONS FOR REFERRAL

1. Penn Foundation EAP will contact the local Affiliate with the following information:
   - Client Name and Phone Number
   - Authorization Number and Expiration date
   - 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: ____ Initial Case ____ Reopen Case ____ Rollover Case ___ Addtl Case
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 _____Age _____ Sex M F
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

Education:
__ 11grades or less/ GED
__ High School Diploma
__ Some College
__ College Graduate
__ Advanced Degree

Race:
__ White
__ Black
__ Hispanic
__ Asian
__ Multiracial
__ Other:_____

Marital Status:
__ Single
__ Married
__ Divorced
__ Separated
__ Living w/ Someone
__ Other

Occupational Status:
__ Hourly Employee
__ Support Staff
__ Clerical
__ Sales/Marketing
__ Manger/Supervisor
__ Administrator
__ Professional

Status:
__ Full Time
__ Part Time
__ As Needed
__ Temporary
__ Other

Length of Service:
__ Under 1 Year
__ 1-3 Years
__ 4-6 Years
__ 7-9 Years
__ 10-15 Years
__ 16 or More Years

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

Shift:
__ Days
__ Evenings
__ Nights
__ Rotating
__ Weekend
__ Other

Been to EAP:
__ No
__ Yes
How many times?_____

Referral Source:
__ Supervisor Mandatory
__ Supervisor Recommended
__ Med Dept/Employee Health
__ Self
__ Co-worker
__ Spouse
__ Friend
__ Human Resources
__ Parent
__ Other:_____

Heard About EAP:
__ Brochure
__ Newsletter/Poster
__ Company Orientation
__ Training/Workshop
__ Supervisor Notification
__ Human Resources
__ Co-Worker
__ Payroll Stuffer
__ Spouse
__ Other:_____

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

Cell/Home/Work # (ok to leave message) _____ email: _____

List of Everyone Living in the Household: **Name/Relationship/Date of Birth &/or Age**:

_____

_____

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 the following: Fitness for Duty evaluations, Return to Work/School Evaluations, FMLA or Disability paperwork, medical diagnosis, or court-related services.

If specialized or on-going counseling is indicated, a referral will be made. If a referral is advised, your EAP counselor will work with you to find an appropriate community resource. Verification of insurance coverage and fees for all referrals is your responsibility and not the responsibility of Penn Foundation EAP.

Confidentiality:
Penn Foundation Employee Assistance Program maintains the highest standards of confidentiality possible under law. The record of your treatment is confidential and written consent is required for any release of information except as permitted by law.

Cancellation of Appointments:
Please give Penn Foundation Employee Assistance Program at least 24-hour prior notice regarding cancellation of an appointment.

Privacy Policy:
By signing below, I acknowledge receipt of a Notice of Privacy Practices that provides a more complete description of health information uses and disclosures.

Consent To Treatment:
In signing my name below, I acknowledge I am giving my informed consent to treatment for myself and/or my minor Child at Penn Foundation Employee Assistance Program (EAP). I understand that I may decline further participation at any time

Client's Printed Name: _____

Client's Signature: _____ Date: _____
(14 years or older)

Parent or Guardian (When Required): _____

EAP Representative/Witness: _____

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.

Contact Name: _____ 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.

If at any time you are unhappy with the services or the counselor you are seeing is not a good fit, please contact the Director or the Office Manager and we would be happy to assign you to a new counselor.

Name: (Please print) _____

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

ADDRESS to mail survey to:

_____

_____

_____

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

Signature_____ Date_____

PENN FOUNDATION EAP

CLIENT SUMMARY/BILLING FORM

Presenting Problem: _____
_____
_____
_____

Brief Case Summary: _____
_____
_____
_____

EAP Still Open _____ EAP Closed _____ Client Referred: __ Yes __No

Referral made to: __ Current Provider ___Other: _____

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

BILLING SHEET

PROVIDER NAME: _____

PROVIDER AGENCY: _____

TAX ID# _____

BILLING ADDRESS: _____

_____ ZIP _____

PHONE: _____ FAX: _____

CLIENT NAME: _____ AUTH # _____ CLIENT #:_____

DATES OF SESSIONS

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

Total Hours _____ x $_____ per hour = $_____

DATE SUBMITTED: _____ (must be within 60 days of date of last service rendered)