

Affiliate Clinical Forms



Well-Being at Work

Procedural Flow Chart

1. Please make contact with the Lytle EAP client within 24 hours of receiving the referral.
2. Every effort should be taken to offer an appointment within 3 days of the referral.
3. Once an appointment has been made, call Lytle EAP Partners with the appointment date and time.
4. After conducting the initial assessment, call Lytle EAP Partners to provide clinical information and determination if case is appropriate for short term resolution.
5. Provide referrals to a long term provider, treatment center, support group or other community resource following the assessment and on an as needed basis through the conclusion of the EAP services.
6. Send the Clinical Service Form no later than 45 days from the last date of service to:
Lytle EAP Partners
Attn: Clinical Intake Department
200 Cedar Ridge Drive, Suite 208
Pittsburgh, PA 15205
Clinical Fax Number (412) 921-7261
7. Payment will be made within 45 business days of received invoice.

PLEASE DO NOT STRAY FROM THIS PLAN WITHOUT FIRST CONTACTING LYTLE EAP PARTNERS.

Affiliate Scope of Services

Scope of Services:

In addition to EAPA's Standard of Care, an Affiliate shall provide the following services in the manner indicated:

1. Affiliate's activity will be focused on assessment, short term (EAP) counseling, and when appropriate, referral of clients to community resources in such a manner as to maximize the client's ability to address and resolve his/her problem(s).
2. Affiliate will collect and record pertinent information about the client, including health history, family status, and other data deemed appropriate for the determination of the nature of the problem(s). Particular attention will be given to assessing alcohol and/or other drug problems.
3. Affiliate will require each client to sign a Lytle "Release of Information" (as needed).
4. Following the professional assessment, if referrals to a community resource is appropriate, Affiliate will discuss the range of referral options, including self-help groups with the client. Cost to the client and benefit coverage should be discussed at this time.
- 5. Affiliate will NOT contact the client's supervisor or anyone else at the client's place of employment.**
6. Affiliate will make arrangements for the voluntary utilization of a referral resource, when appropriate, and encouragements/motivate the client to follow through.
7. Affiliate will participate in and actively cooperate with Lytle's utilization review, case management and quality assurance programs, including but not limited to, the performance of on-site concurrent review and case management as requested.
8. Affiliate will make every effort to have services accessible and responsive to the needs of all clients. Affiliate will be available for calls from Lytle and clients. Affiliate will have a live answering service, pager, or answering mechanism to facilitate immediate response when necessary.
9. Under emergency conditions, Affiliate will provide an immediate appointment. Under nonemergency conditions, Affiliate will offer an appointment for a client who requests it within three days of the time the client makes contact with Affiliate or Lytle, or any time mutually agreed upon and convenient to the client.
10. Affiliate will make every effort for client appointments to be scheduled on an extended workday basis. Weekend scheduling will be provided if necessary.
11. Affiliate will be responsible for the selection of community resources and subject to Lytle's approval.
12. Affiliate warrants that referral resources will confirm to all licensing and certification requirements as designated by government agencies and professional associations for the performance of services offered.
13. Affiliates that self-refer will notify Lytle EAP Partners.

Client Information Forms

Required Form:

- Clinical Service Form

Please complete all sections and return within 45 business days of last date of service.

Supplemental Forms:

- Statement of Understanding
- Intake Assessment Form
- Consent for Release of Information (to be used only if necessary)
- Consent for Release of Information Supervisory Referral (to be used only if necessary)
- Notice of Policies and Practices to Protect the Privacy of Your Health Information (client may keep)
- Acknowledgement of Receipt of Notice of Privacy Practices

Lytle EAP Partners expects that as a contracted, licensed professional, affiliates provide a thorough assessment, and appropriately notify clients of their rights. If an affiliate is not currently using all of the forms below, we request completion of those forms.

Please make copies of the forms as needed. Or, visit our website, www.lytleeap.com, to print the forms as needed. Do not hesitate to call us if you have any questions at 1-800-327-7488 or 412-921-7000.

Clinical Service Form

Client Name: _____ Client Date of Birth: _____

Case Number: _____ Provider : _____


Client Employer: _____

Payment Information

Tax ID or SSN: _____

Billing Address: _____

Make Check Payable To: _____

<p>Dates of Service:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Date</th> <th style="width: 33%;">Length of Session</th> <th style="width: 33%;">Contracted Rate</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Date	Length of Session	Contracted Rate																												<p>Assessed Concerns (check all that apply)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Alcohol</td> <td><input type="checkbox"/> Interpersonal</td> </tr> <tr> <td><input type="checkbox"/> Crisis</td> <td><input type="checkbox"/> Job Related</td> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Marital</td> </tr> <tr> <td><input type="checkbox"/> Drug</td> <td><input type="checkbox"/> Medical</td> </tr> <tr> <td><input type="checkbox"/> Emotional</td> <td><input type="checkbox"/> Stress</td> </tr> <tr> <td><input type="checkbox"/> Family Problems</td> <td><input type="checkbox"/> Other's Addiction</td> </tr> <tr> <td><input type="checkbox"/> Risky Drinking</td> <td> </td> </tr> <tr> <td><input type="checkbox"/> Other Problem _____</td> <td> </td> </tr> </table>	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Interpersonal	<input type="checkbox"/> Crisis	<input type="checkbox"/> Job Related	<input type="checkbox"/> Depression	<input type="checkbox"/> Marital	<input type="checkbox"/> Drug	<input type="checkbox"/> Medical	<input type="checkbox"/> Emotional	<input type="checkbox"/> Stress	<input type="checkbox"/> Family Problems	<input type="checkbox"/> Other's Addiction	<input type="checkbox"/> Risky Drinking		<input type="checkbox"/> Other Problem _____	
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<p>Recommendations/Referrals Provided</p> <ul style="list-style-type: none"> <input type="checkbox"/> Community Resource _____ <input type="checkbox"/> Human Resource _____ <input type="checkbox"/> Sub. Abuse-Inpatient _____ <input type="checkbox"/> Sub. Abuse-Partial _____ <input type="checkbox"/> Sub. Abuse-IOP _____ <input type="checkbox"/> Sub. Abuse-Outpatient _____ <input type="checkbox"/> Sub. Abuse-Education _____ <input type="checkbox"/> Mental Health-Inpatient _____ <input type="checkbox"/> Mental Health-Partial _____ <input type="checkbox"/> Mental Health-IOP _____ <input type="checkbox"/> Psychiatrist _____ <input type="checkbox"/> Self Help Group _____ <input type="checkbox"/> Medical _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Private Clinician-List Below <input type="checkbox"/> Self Referral (please list two names given to client) <p>Referral #1 (Name/Phone) _____</p> <p>Referral #2 (Name/Phone) _____</p>	<p>Outcomes: (check one)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Completed EAP-No Referral <input type="checkbox"/> Completed EAP See Referrals <input type="checkbox"/> Unable to contact client. No response to calls. <input type="checkbox"/> Client decision not to continue, Affiliate agrees. <input type="checkbox"/> Client decision not to continue, Affiliate disagrees. <input type="checkbox"/> Employment terminated. <p>Problem Status At Closing: (check one)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Resolved</td> <td><input type="checkbox"/> Unchanged</td> </tr> <tr> <td><input type="checkbox"/> Improved</td> <td><input type="checkbox"/> Worsened</td> </tr> </table>	<input type="checkbox"/> Resolved	<input type="checkbox"/> Unchanged	<input type="checkbox"/> Improved	<input type="checkbox"/> Worsened																																										
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Statement of Understanding

Welcome to Lytle EAP Partners. An EAP (Employee Assistance Program) is a confidential resource designed to help individuals resolve problems and address concerns through professional counseling, consultation, assessment and referral, when necessary, to community resources.

Who pays for the service? : The services provided to you by Lytle EAP Partners are free of charge to you but pre-paid by your employer. If you need a referral to a specialized service, those services will not be covered by your EAP benefit, but your EAP counselor will assist you in identifying services that take into consideration your health care benefit coverage and your ability to pay.

Attendance of EAP Sessions: Attending scheduled EAP appointment is important. Every effort will be made to offer you appointment times that are convenient. If you are unable to attend a schedule session, we appreciate at least a 24 hours notice so that we may offer that time to others seeking assistance from the EAP.

Confidentiality: Lytle EAP Partners will maintain strict confidentiality regarding your sessions. Lytle EAP Partners records are kept separate from your employer's and are accessible only to authorized Lytle EAP Partners staff. Information you share in the EAP will not be released outside the EAP without your written permission. The ONLY exceptions are when the information is required by law, such as in cases of child abuse, threat of harm to self or others, or by court order. Another exception could be when there is a threat to property.

Emails: Lytle EAP Partners does not considered Emails a secure form of communication and are vulnerable to unauthorized access. If you communicate confidential or highly sensitive information via email, your therapist will assume that you have made an informed decision to do so, assuming the risk that such communication may be intercepted.

1. Do not use email for emergencies. Due to computer or network problems, emails may not be deliverable. Therapists may not check emails on a daily basis.
2. Email should be brief and are best used for informational updates; cancellations and requests for availability. They should not be used for conducting conversations of a sensitive or clinical nature.
3. Email(s) are part of your legal record here. They will be saved along with the rest of your records.
4. Email may be used to send appointment reminders or psycho-educational material.

Social Media (Facebook, LinkedIn, Twitter, etc.): Some of the therapists may have personal social media accounts or professional social media accounts from other places of business. Please note that our therapists do not accept "Friend" requests from current or former clients. We believe that doing so may compromise confidentiality and could blur the boundaries of the therapeutic relationship. For this reason, please do not request that we connect with you on social media.

Your signature below means that you have read this form and understand its content.

Signature of Client

Date

Signature of Client/Guardian (If Applicable)

Date

Signature of Client/Guardian (If Applicable)

Date

EAP Counselor

Date

- You have my permission to mail a client satisfaction survey to my home.
- You have my permission to mail a client satisfaction survey to my home.
- Do not mail a questionnaire to my home.

Lytle EAP Partners
Intake Assessment Form

Clients Name:

Counselor/Affiliate Name:

Date(s) of Assessment:

Presenting Problem:

Describe Affect/Demeanor:

Describe any relevant family and/or social factors:

Describe Depressive Symptoms: (mood, loss of enjoyment, appetite, energy level, motivation, sleep):

Describe Anxiety Symptoms: (anxious, nervous, worrisome/fearful, panic):

Describe Suicide History: (none, ideation, intent, plan, actions, history):

Describe Homicidal History: (document risk, plan, intent, and counselor's action taken – including safety plan):

History of Violence: (description of any past violence, evidence of any domestic abuse – current, or past):

Other cognitive, behavioral, or emotional symptoms:

Behavioral Health Treatment History:

Describe Current Substance Use: (amount/type/frequency):

Negative consequences of use: Family Legal Health Job Financial
History of Treatment or AA or NA if Yes, Explain

Describe Any Work Related / Performance Issues:

Medical Problems / Medications:

Goals and Plan for EAP Assistance:

Follow-up Appointment Scheduled Date: _____

Referrals Given:

Other:

Signature: _____ Date: _____

Consent for Release of Information

Clinical Referral

I, _____, authorize Lytle EAP Partners and its contracted affiliates (i.e. service providers) to exchange the following types of information for the following purposes:

Lytle EAP Partners may exchange with _____ the following information relating to the clinical services I receive to support continuity of care or to inform them of my status for any of the following:

Social History ____,
Medical Record ____,
Treatment Summary ____,
Psychological Evaluation ____,

and/or

Other _____ Explain: _____

This authorization shall become effective _____ and is subject to revocation in writing by me at any time, except to the extent that action has already been taken. This authorization shall terminate _____ from the effective date, if not earlier revoked. I understand that this information will be used only for the purpose noted above and will not be disclosed to any other person or agency without my written permission.

Signature of Client or Legal Guardian (circle which)

Date

Printed name of Client

Date

Counselor's Signature

Date

Consent for Release of Information

Supervisory Referral

I, _____ authorize Lytle EAP Partners and its contracted affiliates (i.e. service providers) to exchange the following types of information for the following purposes:

I have been referred to the EAP by my employer and, in order to comply with the policies of my employer, I authorize Lytle EAP Partners to release the following non-medical information to my employer: (A) whether I have kept initial and/or subsequent appointments, (B) whether a course of treatment was recommended by the EAP counselor, (C) whether I am following the recommended course of treatment, and/or (D) whether I have completed the recommended course of treatment.

Other (Please Describe)

This authorization shall become effective _____ and is subject to revocation in writing by me at any time, except to the extent that action has already been taken. This authorization shall terminate _____ from the effective date, if not earlier revoked. I understand that this information will be used only for the purpose noted above and will not be disclosed to any other person or agency without my written permission.

Signature of Client or Legal Guardian (circle)

Date

Printed name of Client

Date

Counselor's Signature

Date

LYTLE EAP PARTNERS

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW EAP INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Program Eligibility and Costs

Lytle EAP Partners offers assessment, referral, and short term counseling services. Services provided within the Assistance Program (AP) system are offered at no cost to you. Your organization has already paid for these services. If longer term counseling, community support services, specialized services or treatment is needed, referrals to services or providers outside of Lytle EAP Partners may be recommended to help you resolve problems. Those services may be offered at no cost (i.e., self-help groups) or covered under a medical benefit plan offered by an organization or insurer. However, it is your responsibility to determine whether or not services are covered under any such plan. Charges for any services provided by any outside community resource are your responsibility.

II. Uses and Disclosures for Treatment, and Health Care Operations

Lytle EAP Partners may *use* or *disclose* your *protected health information (PHI)*, for *treatment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
- *Treatment* is when Lytle EAP Partners provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when Lytle EAP Partners consults with another health care provider, such as your family physician, Drug/Alcohol treatment facility, or another therapist.
- *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

III. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your EAP notes. “*EAP notes*” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your EAP record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or EAP notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the

authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Your PHI will not be used and/or disclosed for marketing and fundraising purposes, or sold without your knowledge.

IV. Uses and Disclosures with Neither Consent nor Authorization

Lytle EAP Partners may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If Lytle EAP Partners has reasonable cause, on the basis of our professional judgment, to suspect abuse of children with whom we come into contact in our professional capacity, we are required by law to report this to your state's Department of Public Welfare.
- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat, we must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

V. Client's Rights and EAP Duties

Client's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen in the EAP. Upon your request, we will contact you at another phone number or address.
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section IV of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from Lytle EAP Partners upon request, even if you have agreed to receive the notice electronically.

Lytle EAP Partners Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide notice by mail to you.
- We are obligated to maintain the privacy of an individual's PHI and you have the right to be notified if a breach occurs.

VI. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Lynn Carrick, EAP Supervisor at 412-357-9547.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VII. Precertification/Managed Care

If the Assistance Program is performing precertification functions, this precertification is for clinical appropriateness only, and does not guarantee that insurance providers will reimburse clients for recommended treatment or therapy. Therefore, it is the ultimate responsibility of the client to assure that the recommended treatment will be reimbursed by the benefit provider (i.e., cases involving pre-existing conditions, exempted conditions, etc.).

If you have any additional questions or comments about your experience, feel free to ask any staff member, or call our 24-hour, toll free line.

VIII. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by mail.

Lytle EAP Partners

Acknowledgment of Receipt of Notice of Privacy Practices

Under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are required to attempt to obtain your written acknowledgement of receipt of the Notice of Privacy Practices.

By signing this form, I acknowledge receipt of the Lytle EAP Partners'. Notice of Privacy Practices.

Signed: _____

Date: _____

Print Name: _____