

STATEMENT OF UNDERSTANDING

You have chosen to receive employee assistance program (“EAP”) services which are provided through a Magellan Healthcare* company (“Magellan”). EAP services may include assessment and referral or brief counseling. The EAP counselor will work with you to clarify the problem, identify choices, and develop an action plan. Magellan customer service associates and EAP consultants are available to respond to your call 24 hours a day, 365 days a year.

FEES

These services are provided at no direct cost to employees and family members. The employee's company pays for the services. However, if you need longer-term counseling or a specialized service, Magellan will assist in locating a resource or service in the community. **It is your responsibility to pay for services provided by any resources outside the EAP.** (Your benefit plan may cover some of the cost. **Check with your benefits representative before services are provided by outside resources.**)

CONFIDENTIALITY

The EAP will maintain confidential records of your contact with the EAP and the services provided to you in order to provide continuity and coordination of your care.

No one will reveal information concerning your use of the EAP to anyone outside the program except as follows: (1) you consent in writing; (2) life or safety is seriously threatened; (3) disclosure is required by law; or (4) your counselor refers you to benefits-covered treatment and the claims pay or requires information. In addition, your counselor will disclose information and records to Magellan as needed for coordination of EAP services, quality assurance, or payment. Professional auditors (not employed by the employee's company) may also examine your file to evaluate the services. Depending on the privacy policy of the employer, the employer's privacy official might have access to information in connection with the employer's obligations in the Privacy Rule under HIPAA (the Health Insurance Portability and Accountability Act). Check the employer's privacy policy to see if the privacy official or anyone else will have access to information.

IF YOU HAVE BEEN REFERRED TO THE PROGRAM DUE TO A WORK PERFORMANCE PROBLEM:

Under your employer's policy,

- 1) Magellan is expected to confidentially advise the referral source whether you are participating in the EAP and cooperating with the EAP plan. To permit Magellan to do so, you will need to sign an authorization permitting disclosure of that information. However, you may use EAP services even if you do not sign an authorization. Your personal problems will not be discussed with the referral source, unless you request, in writing, that this be done.
- 2) Participation is voluntary--whether or not you decide to use the EAP services, your decision will not affect your employment security or advancement opportunities.

I, (print name) understand this form, including the confidentiality of the EAP and the limitations to confidentiality, and accept it as the terms of my participation in the program. As an EAP consumer, I also understand that I may request written information describing Magellan's confidentiality policy and/or the EAP counselor's confidentiality policy.

Signature

Parent, guardian, or legal representative (when required)

Witness

Date

Counselor Signature:

Initial if a copy was given to client.

Client Information Form

Client Name: _____

Case # _____ [Magellan will supply the number]

First Appointment Date: _____

Address:		City:
State:	ZIP:	Do we have permission to contact you at the above address? <input type="checkbox"/> Yes <input type="checkbox"/> No

Gender: Female Male **Date of Birth:** _____

Work Telephone Number:	May we call you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Telephone Number:	May we call you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Number:	May we call you at this number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Employer or Organization through which you are accessing EAP:

Employee's Name:	Employee's Job Title:	Length of Service:
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Your Status: Employee Employee Spouse Employee Child Other
 Retiree Retiree Spouse Retiree Child

Do you have health coverage? Yes No (if Yes) **Name of organization(s) through which you are covered:** _____

How did you access the EAP?

<input type="checkbox"/> Self-Referral	<input type="checkbox"/> Family Initiated	<input type="checkbox"/> Medical Department Referral/Human Resources	<input type="checkbox"/> Primary Care Physician Referral
<input type="checkbox"/> Supervisor Recommendation (Informal)	<input type="checkbox"/> Supervisor Referral (Formal)	<input type="checkbox"/> Mandatory Supervisor Referral	<input type="checkbox"/> Other: _____

Were you referred for a work performance problem? Yes No

If yes, please indicate the type: Absenteeism / Tardiness Safety / Security Work Relationships Quantity / Quality of Work Positive Alcohol / Drug Test Other

What concerns brought you to the EAP?

What do you want to see happen as a result of coming here?

What have you tried on your own to solve your concerns?

Healthy Habit Information (please base your answers on the past month):

- ° Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit? Yes No
- ° Have you been dieting to lose weight? Yes No NA
- ° Have you smoked cigarettes on a daily basis? Yes No

How often in the past month did you drink alcohol?

I do not drink at all About once a month 2 to 3 times a month 2 to 3 times a week Once a day or more

OPTIONAL:	Education (Years completed or degree earned): _____	Legal Issues <input type="checkbox"/> Yes <input type="checkbox"/> No	Financial problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Military Service: Branch(es): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Present <input type="checkbox"/> Past
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Client Signature _____

Date _____