VALUEOPTIONS

EAP CASE ACTIVITY AND BILLING FORM

Instructions: Please print and complete ALL information. Please use ink. **Billing Type: ☐ Interim ☐ Final ☐ Re-Open**

PAYER (the corporate client, employer, company/division, location or department through which EAP benefits are available)

Payer Name:

EAP PARTICIPANT DEMOGRAPHIC INFORMATION

Last Name(s): _____ First: _____ MI: _____ Participant Gender: □ Female □ Male
(**Please also enter the participant name and employee Social Security Number in the appropriate area on the reverse side of this form)**

Correspondence Address: _____ Participant DOB: ____/____/____

City: _____ State: _____ ZIP: _____ Home Phone: ( ) _____

Employee Name (if not participant): Last: _____ First: _____ Employee Social Security Number: _____/ _____ / _____

□ Statement of Understanding Signed □ Release of Information Signed

Participant Category: ☐ Self ☐ Spouse ☐ Dependent ☐ Sibling ☐ Parent ☐ Unmarried Partner ☐ Other

Learned About EAP: ☐ Word of Mouth ☐ Printed Materials ☐ Electronic Media ☐ Union Representative ☐ Training / Health Fair ☐ Company Representative

Service Provider: ☐ ValueOptions Staff Office ☐ ValueOptions EAP Affiliate ☐ Internal EAP ☐ On-Site EAP

Relationship Status: ☐ Never Married ☐ Married ☐ Separated or Divorced ☐ Widowed ☐ Cohabitating

Referral Source: ☐ Self ☐ Union ☐ Co-worker ☐ Medical/MRO ☐ Human Resources ☐ Internal EAP ☐ Wellness Program ☐ Treatment Provider ☐ Worksite Representative

Ethnicity: ☐ African-American ☐ Native American ☐ Asian / Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Multiracial ☐ Arab-American ☐ Other

BILLING INFORMATION (Please keep a copy for your records. Form should be submitted to the billing address as indicated on the EAP authorization letter for the participant.)

Date(s) of Service (MM/DD/YY):									
Total Sessions Billed:									
Number EAP Sessions Used at Case Closing:									

EAP Clinician Name & Credentials: (please print) _____ **EAP Clinician Signature:** _____ **Date:** _____

Phone: ( ) _____ **SSN OR Tax ID:**_____ **EAP Clinician Billing Address:** _____

EMPLOYMENT DATA (Complete only if employee is participant.)

Employment Status: ☐ Full Time ☐ Part Time ☐ Terminated ☐ Medical Leave ☐ Retired ☐ Disciplinary Leave ☐ Laid Off ☐ Disability/WC Leave ☐ Other **Union Member** ☐ Yes ☐ No

Job Title Category: ☐ Executive/Manager ☐ Professional ☐Technical ☐ Sales ☐ Office/Clerical ☐ Craft Worker- (skilled) ☐ Operative- (semi-skilled) ☐ Laborer- (unskilled) ☐ Service Worker

Job Dysfunction: ☐ None ☐ Minimal ☐ Moderate ☐ Significant- no job jeopardy ☐ Significant- job jeopardy

Job Problem Category: ☐ Absenteeism ☐ Fitness for Duty ☐ Safety Issue(s) ☐ Unpaid Leave(s) ☐ Tardiness ☐ Positive Drug Screen ☐ Productivity Issue(s) ☐ Co-Worker Relationship ☐ Supervisor Relationship ☐Aberrant Behavior ☐ Work Performance ☐ None

Participant Last Name: _____ **First:** _____ **Employee Social Security Number:** _____/ _____ / _____

PRESENTING VS. ASSESSED PROBLEM

From the list below, choose one Presenting Problem (P), one Primary Assessed Problem (A_1)

Addictions

P	A_1	
□	□	Alcohol
□	□	Drug
□	□	Poly-substance
□	□	Other _____

Emotional / Psychological

P	A_1	
□	□	Anxiety
□	□	Depression
□	□	Disability
□	□	Eating Problem
□	□	Hyperactivity / Inattention
□	□	Impulse Control Problem
□	□	Other Mood Disturbance
□	□	Thought Disorder
□	□	Other _____

Psychosocial / Environmental

P	A_1	
□	□	Child Care
□	□	Family Problems
□	□	Financial
□	□	Grief / Loss
□	□	Job / Occupational
□	□	Legal
□	□	Marital / Relationship Issues
□	□	Other _____

Medical

P	A_1	
□	□	Medical Problem

RISK ASSESSMENT

	None	Mild	Moderate	Severe	Notes
Suicidality	☐	☐	☐	☐	
Potential for Violence/Abuse	☐	☐	☐	☐	

FUNCTIONAL ASSESSMENT

Complete at case opening (O) and case closing (C)

	No Evidence of Impairment		Mild Impairment		Moderate Impairment		Severe Impairment	
	O	**C**	**O**	**C**	**O**	**C**	**O**	**C**
Mood/ Affect (Depression; Mania/ Elevated Mood)	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety/ Panic	☐	☐	☐	☐	☐	☐	☐	☐
Psychosis / Hallucinations	☐	☐	☐	☐	☐	☐	☐	☐
Thinking/ Cognition/ Memory/ Concentration	☐	☐	☐	☐	☐	☐	☐	☐
Impulsive / Reckless / Aggressive Behavior	☐	☐	☐	☐	☐	☐	☐	☐
Activities of Daily Living Problems (personal hygiene, routine household tasks)	☐	☐	☐	☐	☐	☐	☐	☐
Weight Loss (Unintentional)	☐	☐	☐	☐	☐	☐	☐	☐
Medical or Physical Conditions	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse / Dependence (alcohol, illicit drug, Rx drug)	☐	☐	☐	☐	☐	☐	☐	☐
Job / School Performance Problems	☐	☐	☐	☐	☐	☐	☐	☐
Social Functioning / Relationship/ Marital/ Family Problems	☐	☐	☐	☐	☐	☐	☐	☐
Legal Problems	☐	☐	☐	☐	☐	☐	☐	☐

GOALS

	Met	Partially Met	Not Met	No Change
1.	☐	☐	☐	☐
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐

CASE CLOSING

Problem Status at Case Closing

☐ Problem Resolved
☐ Problem Partially Resolved
☐ Problem Getting Worse
☐ No Change in Problem Status
☐ Not Applicable

Case Disposition

☐ Face-to-face assessment/no referral
☐ Face-to-face assessment/referral accepted
☐ Face-to-face assessment/referral declined
☐ EAP Participant did not keep initial appointment
☐ EAP Participant withdrew before Completion of services

Referral

☐ Substance Abuse Treatment
☐ Psychiatric Treatment
☐ Medical Treatment
☐ Community Resource

EAP / Psychiatric / Substance Abuse Treatment History Assessed: ☐ Y ☐ N Notes:

Strengths, Skills, Aptitudes & Interests Assessed: ☐ Y ☐ N Notes:

Supports Assessed: ☐ Y ☐ N Notes:

Military History Assessed: ☐ Y ☐ N Notes: