Affiliate Clinical Forms

Well-Being at Work

LYTLE EAP PARTNERS
Well-being at work

Introduction

Lytle EAP Partners is an independent consulting and service organization that provides development, implementation, and administration of behavioral care programs to business, industry, and various other organizations. Lytle EAP Partners provides a full range of integrated Employee Assistance and Wellness programs including: Employee Assistance Programs (EAP), Member Assistance Programs (MAP), Substance Management Programs, Critical Incident and Crisis Services, Work/Life Programs, and Wellness Programs.

Lytle EAP Partners' purpose is to provide consultation and program services to our clients in the areas of behavioral healthcare. The cornerstone of all Lytle EAP Partners programs is responsive customer service and the delivery of direct clinical services.

Disclaimer

The information contained in this packet is for informational purposes only, and is not intended to be nor shall be construed as any type of contract. The information provided in this packet is subject to change at any time. Any contractual relationship which any affiliate which may form with Lytle EAP Partners is stated solely by the terms and conditions of the Affiliate Agreement and Business Associate Agreement, copies of which will be given to affiliate. (The agreement may change from time to time.)

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Procedural Flow Chart

1. Employee or family member calls Lytle EAP Partners (Lytle).

2. Lytle's Intake Counselor completes brief intake.

3. Lytle contacts Affiliate and provides Affiliate with client information.

4. Affiliate contacts client and offers an appointment with client to be held within the next three days.

5. Affiliate contacts Lytle to inform Lytle of the time the counseling appointment is scheduled.

6. Affiliate conducts assessment with client.

7. Affiliate calls Lytle to provide assessment information and determination if case is appropriate for short term services. If so, Lytle authorizes further sessions.

8. The affiliate will make appropriate 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 service.

9. Affiliate sends Lytle the required client information, signed forms, and billing invoice no later than 45 days from the service date(s) to:
   Lytle EAP Partners
   Attention: Clinical Intake Department
   200 Cedar Ridge Drive, Suite 208
   Pittsburgh, PA 15205

10. Affiliate follows up with client, as needed.

11. Affiliate receives payment from Lytle within 45 days of Lytle's receipt of completed and approved information.

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

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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 "Statement of Understanding", a "Release of Information" (as needed), and an "Acknowledgment of Receipt of Notice of Privacy Practices".

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. Organizations that self-refer must have the client sign the "Treatment Waiver Form".

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Well-being at work

Client Information Forms

These forms include:

1. Statement of Understanding
2. Intake Assessment Form
3. Clinical Service Closing Form
4. Consent for Release of Information (to be used only if necessary)
5. Consent for Release of Information Supervisory Referral (to be used only if necessary)
6. Notice of Policies and Practices to Protect the Privacy of Your Health Information (client may keep)
7. Acknowledgement of Receipt of Notice of Privacy Practices
8. Invoice Form
9. Treatment Waiver Form

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

LYTLE EAP PARTNERS
Well-being at work

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.

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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):

LYTLE EAP PARTNERS
Well-being at work

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:_____

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Clinical Service Closing Form
Lytle EAP Partners

Client's Name:_____ **Authorization Number:**_____ **Date of Birth:**_____

Provider Name:_____ Phone:_____ Fax:_____

Date(s) of Service:_____

Date of Closing Session:_____

Disposition: (check one)

- ☐ Completed EAP No Referral
- ☐ Completed EAP See Referrals
- ☐ Unable to contact client. No response to calls.
- ☐ Client decision not to continue and Affiliate agrees.
- ☐ Client decision not to continue and Affiliate disagrees.
- ☐ Employment terminated or no longer eligible.

Referral Type:

- ☐ Community Resource
- ☐ Human Resource
- ☐ Substance Abuse-Inpatient
- ☐ Independent Therapist
- ☐ Medical
- ☐ Career Counseling
- ☐ Self Help
- ☐ Other

If client was referred to individual provider, please provide info:

Referral #1

Name:_____

Phone:_____

Referral #2

Name:_____

Phone:_____

Self-Referral Offered:

If self-referral services are needed, Lytle EAP Partners requires that an EAP Affiliate (1) contact Lytle EAP Partners and obtain authorization; (2) provide the client with at least two other referral sources; (3) have the client sign the "Treatment Waiver Form" and inform the client of potential financial responsibility for referrals beyond EAP services.

Job Status At Close: (check one)

- ☐ Unchanged
- ☐ Resigned/Retired
- ☐ Terminated
- ☐ Disability
- ☐ Workers' Compensation
- ☐ Other
- ☐ Don't Know

Benefits Used After EAP: (check one)

- ☐ Mental Health Inpatient
- ☐ Mental Health Outpatient
- ☐ Medical Benefits
- ☐ None Available
- ☐ None Necessary
- ☐ Substance Abuse Inpatient
- ☐ Substance Abuse Outpatient

Problem Status At Closing: (check one)

- ☐ Resolved
- ☐ Improved
- ☐ Unchanged
- ☐ Worsened
- ☐ Don't Know

Required forms needed for closing and final payment:

- ✓ Intake Assessment
- ✓ Release of Information (if needed)
- ✓ Treatment Waiver Form (if applicable)
- ✓ Statement of Understanding
- ✓ Clinical Closing Form
- ✓ Invoice(s)

Affiliate Signature:_____ Date:_____

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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

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Well-being at work

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

Well-being at work

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.

LYTLE EAP PARTNERS
Well-being at work

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.

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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:_____

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Lytle EAP Partners
Affiliate Reimbursement Summary

Payment will be authorized to the Affiliate only when Lytle EAP Partners receives the appropriate paperwork and invoice no later than 45 days from the service date(s). Lytle EAP Partners will authorize payment to an Affiliate for actual services rendered within 45 working days of the Affiliate's completing the

Lytle EAP Partner's receipt of the following documents:

1. A signed Statement of Understanding
2. A completed Intake Assessment Form
3. A completed Clinical Service Closing Form
4. An Authorization for Disclosure of Protected Health Information Signature Page
5. A signed Consent for Release of Information (only as needed)
6. Acknowledgement of Receipt of Notice of Privacy Practices
7. A completed Affiliate Invoice

The Affiliate acknowledges that Lytle EAP Partners only agrees to pay for preapproved authorized sessions.

A "Treatment Waiver Form" needs to be completed and returned to Lytle only if you, the affiliate, have been pre-authorized by Lytle to make a self-referral.

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Affiliate Invoice

Affiliate Name:	**Tax ID Number:**
Affiliate Address:	
Client Name:	**Client Authorization #:**
Name of company in which client works:	

Date(s) of Assessment	Amount of Time	Rate/Session	Total
Total Amount Due:			

For Compensation Send Invoice To:

Lytle EAP Partners
Attn: Coordinator of Clinical Intake
200 Cedar Ridge Drive, Suite 208
Pittsburgh, PA 15205
Clinical Fax Number: (412) 921-7261

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Lytle EAP Partners

TREATMENT WAIVER FORM

To be used, when applicable, for all self-referral situations; send in with invoice

Case #: _____ Name of Provider: _____

Clarification: Lytle EAP Partners' Self-Referral Policy and need for Treatment Waiver Form

Lytle allows its EAP providers to refer to themselves, or "self-refer" under the circumstances such as clients need for long-term counseling, therapy, or substance abuse treatment, however; to protect our clients from a potential conflict of interest, we require that this "Treatment Waiver Form" be provided, explained, and signed by our clients requesting services beyond the EAP. Self-referrals are encouraged for client continuity when both ethically and clinically indicated and not as a way of generating business for themselves, their group practice, or Lytle. To ensure that the client is empowered with choices, Lytle requires that in all self-referral situations, the EAP Provider provide two additional referrals other than themselves or any other person, or organization where they may have financial interest, before asking the client to sign off.

PROVIDER: Document resources, other than yourself, offered to client. You must provide Lytle clients with a minimum of two additional referrals.

This form must be completed if you, or someone within your group practice, continue to see the client through their insurance benefits or private pay after the assessment or EAP sessions are complete. The following two referrals need to be provided to the client at the final EAP session when referring into insurance benefits or private pay.

Referral: _____ Phone: _____

Referral: _____ Phone: _____

I, _____, am requesting to continue counseling beyond my EAP/MAP benefits
(Print Client Name)

with _____, a Lytle affiliate provider.
(Print Provider Name)

I understand that Lytle EAP Partners' requires that its EAP Affiliates provide at least two additional referrals to other clinicians or services for which they have no financial interest, as this type of situation may pose a conflict of interest for me. I understand that I am not obligated to use any of these resources or continue seeing Lytle's Provider. I understand that I will be responsible to determine if a Provider and/or a particular service is covered by my health insurance benefits plan. I understand that I will be responsible for all services rendered beyond the scope of my EAP benefit.

_____ _____
Clients Signature Date

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