

Federal Occupational Health (FOH) Employee Assistance Program

Introduction

Federal Occupational Health (FOH), an agency within the Department of Health and Human Services (HHS), contracts with Magellan to provide an EAP for a consortium of government agencies.

This appendix provides important account-specific information about the FOH EAP. For complete policies and procedures for Magellan EAP providers, please reference the other sections of this handbook supplement. Any questions about the FOH EAP or the contents of this section of this appendix should be directed to Magellan's FOH EAP care managers at: **1-800-888-0364**.

FOH EAP Service Center
Magellan Behavioral Health
14100 Magellan Plaza Drive
Mail Stop MO22
Maryland Heights, MO 63043

Dos and Don'ts

- You are not to grant interviews or provide any information to any form of media regarding individual clients, FOH customer agencies, or Magellan (or FOH) policies or procedures.
- You are not to provide any written or verbal communications to FOH customer agencies or their management or other officials regarding fitness-for-duty or requests for time off. Federal agencies require physician documentation regarding fitness-for-duty, time off, etc., and will not accept documentation from the FOH EAP.
- You are not to contact FOH customer agency personnel regarding a client. All communication must go through Magellan's FOH EAP field consultants or FOH EAP care managers.
- You **MAY** provide a note confirming session attendance, including date and time, if the client makes this request and signs an Authorization to Use or Disclose Confidential Information form.

Dual-Client Relationship

- Within the consortium of FOH customer agencies, there are civilian and military employees, unions, and many layers of management; it is key that the EAP, including EAP providers serving the program, maintain neutrality and confidentiality for both the client and the customer organization in all aspects of service delivery. You are not to contact the client's supervisor, union representative or any other FOH customer agency personnel directly. The FOH EAP field consultant or FOH EAP care manager will provide information to those sources where appropriate and with the proper authorization.

Appendix E – Federal Occupational Health

FOH EAP Components

Self Referrals

Federal employees and/or household members may access the FOH EAP by calling the FOH EAP toll-free number at 1-800-222-0364 (for hearing-impaired members, TTY 1-888-262-7848) to request services.

Management Referrals

Supervisors may formally or informally refer employees who demonstrate job performance, attendance, and/or other conduct problems to the EAP.

An informal management referral occurs when a manager recommends the EAP or reminds an employee about the EAP when the employee discloses a personal issue to the manager.

A formal management referral occurs when, after consulting with Magellan, a manager provides an employee with a referral to the EAP as a resource to assist with an ongoing job performance issue or conduct issue. You, the EAP provider, are expected to meet with the employee to both assess the supervisor's concerns and evaluate the employee's perception of the problem(s) identified by the supervisor and any other problems that the client may identify. These cases must be staffed with the Magellan FOH EAP care manager after the first session; you will also need to report attendance to the care manager after each subsequent session.

At no time should you be in direct contact with the employee's agency personnel regarding the employee. All contact with the employee's agency MUST be with Magellan.

Critical Incident Stress Management (CISM)

EAP providers may be asked to provide face-to-face individual and/or group support to persons who have experienced threats or actual violence, either in the workplace or at another location; threats or actual acts of suicide or homicide; events that severely impact the worksite, such as natural or man-made disaster, death, severe injury or traumatic experience by members of a work group; or any other situation that might have psychological, legal and/or media impact on a customer agency.

United States Coast Guard: All CISM sessions performed for the Coast Guard—**without exception**—must be conducted by clinicians certified by the **International Critical Incident Stress Foundation, Inc.**

If Magellan requests you to conduct a CISM service, fee arrangements will be made at that time by a Magellan representative.

Health and Wellness Presentations

FOH provides EAP orientations to employees and supervisors. In addition, a variety of health and wellness presentations are offered. Most presentations are about an hour in length. EAP providers may be asked to conduct health and wellness presentations onsite at customer locations. If Magellan requests you to conduct a presentation, fee arrangements will be made at that time by a Magellan representative.

Appendix E – Federal Occupational Health

Administrative Procedures

Appointment Procedures

- FOH clients access their EAP by calling 1-800-222-0364 (TTY 1-888-262-7848).
- Each call is answered live by a customer service associate (CSA) at Magellan's FOH EAP National Service Center.
- The CSA obtains demographic data and assigns a referral number.
- The CSA facilitates a referral to a Magellan EAP provider.
- Magellan's FOH EAP National Service Center staff will assist the client in contacting the assigned EAP provider to arrange an appointment.
- Appointments must be offered for times that are convenient to employees and/or their family members. Clients with urgent situations (cases involving risk of harm, abuse, or other circumstances in which a client appears currently stable but is at serious risk to deteriorate without timely intervention) must be offered an appointment within 24 hours; clients with non-urgent (routine) cases must be offered an appointment within 72 to 120 hours (3 to 5 days). If you are unable to provide appointments to meet these time frames, contact the FOH EAP National Service Center at 1-800-222-0364.
- The confidentiality of all FOH EAP clients must be protected under the Privacy Act of 1974. FOH EAP clients may not be required to provide a Social Security Number to access EAP services.

Follow-Up Procedures

Magellan care managers for the FOH EAP are master's level or higher licensed clinicians who provide care management on all cases involving clinical high risk, substance abuse, job jeopardy, employee high visibility, supervisor referral or other complex issues. You are expected to contact the FOH EAP care manager to discuss your initial assessment before the third appointment with the employee or family member when a case involves any of the above issues.

Documentation

Beginning with the first client contact, you are to maintain a record of contacts with and/or in connection with each client, with the most recent information at the front of the record. Notes are to contain as little identifying information as possible. You are responsible for ensuring that every client record is legible, orderly, accurate, and complete. Every action you take must be documented. The subjective, objective, assessment and plan (SOAP) or another similarly structured method of documentation is to be used to record on-going progress notes; each note must contain your signature.

Upon each case assignment, you will receive a packet of information that includes:

- EAP Referral Sheet with case-specific information (e.g., client name, number of sessions, presenting problem).
- EAP provider letter explaining the FOH EAP.
- Statement of Client Understanding (SOU) that *each* client is required to sign prior to receiving EAP services. The **FOH EAP has a SOU that is specific for the account; this is the only SOU that is to be used for FOH cases** (included in this appendix). *Note:* every adult in the session must sign an SOU. Depending on your state law, the SOU for a minor client must be signed by the minor and/or his or her parent or other legal guardian. If state law requires that one or both parents or legal guardian consent to treatment, then that person or persons must also sign the SOU. If the minor is permitted to consent to treatment on his or her own, only the minor need sign the SOU. Review the SOU with the client to assure his/her understanding of the nature of EAP services.

Appendix E – Federal Occupational Health

If the client has a question that you cannot answer, refer the client to the FOH EAP care manager listed on the referral sheet.

- Consent to Treatment for a Minor form that a parent with legal custody or a legal guardian signs if the client is a minor who is not able to consent to treatment on his or her own under applicable state law.
- Consent for release of confidential information (see Authorization to Use or Disclose Confidential Information and Record Inquiry/Request forms included in this appendix) that the client is required to sign only if records/information are to be released.
- EASI form, which is completed and submitted by you to Magellan upon case closing, for payment. Please note that EASI forms must be received by Magellan within 90 days of the EAP referral end date; see Payment Procedures below.
- FOH EAP Client Satisfaction Survey, which you should give to the client at the last session or mail to him or her at case closure.

Payment Procedures

At no time, under any circumstance, may a client or a client's health benefit plan—or anyone other than Magellan—be billed for services rendered under the FOH EAP.

- To receive payment for EAP sessions rendered, you must submit the EASI form to Magellan. The EASI form must be *received* by Magellan within 90 days of the EAP referral end date indicated on the Magellan referral sheet.
- When the case is closed, you must complete both pages of the EASI form. The billing address is: Attn: FOH EAP Provider Coordinator, Magellan Behavioral Health, 14100 Magellan Plaza Drive, Mail Stop MO22, Maryland Heights, MO 63043.
- Billing on CMS forms or Magellan's Treatment Request Forms **will not** be accepted.
- Magellan will arrange and pay for any interpreter services that are needed for clients with special language needs. Interpreters/translators will submit their invoices directly to Magellan.

In accordance with Magellan's policy, you will not be paid for FOH EAP clients who do not show for or who cancel their appointments. If your office has a policy regarding no-show or cancelled appointments, we recommend that you provide a copy of the policy to the client no later than the first session. If the client fails to show up for or cancels an appointment, you may bill the client directly for the cancellation fee in accordance with the policy you have provided the client.

Service Delivery

Number of Sessions Available

- This program is based on the needs of the client within the framework of a brief, short-term EAP counseling model. Four different session models are available for agencies to choose for their employees – 1 to 3 sessions, 1 to 4 sessions, 1 to 6 sessions, and 1 to 8 sessions. The EAP referral sheet in your FOH EAP provider packet will indicate the total number of sessions in the session model selected by the customer agency through which your client is eligible for EAP services.
- If the initial assessment suggests that care longer than the sessions available in the model is needed, or if at any time during the short-term counseling process a need for longer care is indicated, a referral should be facilitated at once to the client's health benefit plan or other community resource. Please notify the FOH EAP care manager that a referral has been made.

Appendix E – Federal Occupational Health

Care Management

- If you are assigned a priority or high-profile case that involves **risk of violence, substance abuse/misuse, suicidal or homicidal ideation, domestic violence, sexual assault, elder or child abuse, formal supervisor referral, last chance agreement, duty to warn, or chemical dependency, you must staff the case with the FOH EAP care manager upon completing the initial assessment.** If any of these issues are not the presenting problem, but are identified at any time during the EAP intervention, you must immediately staff the case with the FOH EAP care manager. Please remember that FOH EAP care managers are available to consult with you for any program questions, to staff priority, high-profile and problematic cases, and to be of general support to you.
- If you are a first-time EAP provider for the FOH EAP, you will receive a call from Magellan's FOH EAP staff to help orient you to the FOH EAP and answer any questions you may have regarding the items listed in this document.

Referrals

- If the initial assessment suggests that long-term care is needed, or at any time during the short-term EAP counseling process a need for longer-term care is indicated, a referral is to be facilitated to the client's health benefit plan or other community resource. Please notify the FOH EAP care manager that a referral has been made.
- You may make referrals, as necessary, to appropriate resources within the community. You are expected to discuss a range of referral options, including self-help groups and/or professional resources eligible under the client's health benefit plan.

Under FOH guidelines, an EAP provider may offer himself/herself as a referral source for longer-term counseling to an EAP client, but only if staffed with and approved by an FOH EAP care manager in advance. The EAP provider is generally required to also offer the client a choice of two other mental health providers in addition to himself/herself. If the self-referral is approved, the EAP provider must have the client sign the FOH EAP Self-Referral Waiver form.

Appendix E – Federal Occupational Health

Services Not Available Under the FOH EAP

If the client requests these or other services, refer the client back to the program at 1-800-222-0364 for additional resources:

- Court-ordered therapy
- Custody evaluations
- Fitness-for-duty evaluations
- Evaluations for workers' compensation claims, disability claims or other legal proceedings
- Psychological testing
- Group therapy
- Outplacement job search
- Financial counseling for investments
- Learning disability testing
- Drug testing
- Legal advice
- Services outside the established counseling office.

Subpoenas or Requests for Clinical Records

- EAP providers may receive subpoenas in connection with EAP cases. A subpoena should not be confused with a court order. A subpoena is a legal document that is generally issued by an attorney or court clerk. A subpoena is usually not signed by a judge and therefore may not require compliance. A valid court order from a court of competent jurisdiction, on the other hand, is signed by a judge and generally will require compliance. Please refer to your legal support for guidance or contact the Magellan FOH EAP care manager.
- If a client or any other party requests a client's records, please have the requester complete the Record Inquiry/Request form and the Authorization to Use or Disclose Confidential Information form (included in this appendix). See Summary of Privacy Act Requirements for details on legal requirements for responding to requests for records.
 - You, the EAP provider, must obtain appropriate means of identification to verify the identity of the requester.
 - When the client requests the record, the client must name a designated representative to receive the record if you think that access to any part of the record could be harmful if given directly to the client. The client may name you as the designated representative if you feel comfortable discussing the information with the client.
 - If the client is a minor child, the record may not be released directly to the parent or guardian; it may only be released to the designated representative.
 - If you have any questions regarding this process, contact the Magellan FOH EAP care manager.

Delivering Services to Clients with Disabilities

- **Visually Impaired Clients:** You should read aloud all forms that are presented to clients for examination and/or signature (e.g., Statement of Client Understanding, Authorization to Use or Disclose Confidential Information). You should document the reading in the client's case record, including the client's response to the reading.
- **Hearing Impaired Clients or Clients with Special Language Needs:** If an interpreter/translator is required for a hearing-impaired client or a client who has special language needs, the FOH EAP National Service Center will locate an interpreter/translator and coordinate services between you and the interpreter. When an interpreter is utilized, you are to obtain the client's signature on a "Consent to Presence of Translator/Interpreter" form (included in this appendix).
- **Physically Impaired Clients:** Your office, restrooms and parking facilities must be fully accessible to persons with physical disabilities. When your office cannot accommodate a physically disabled client, you are to arrange for an alternative accessible location in which the client can receive services.

Federal Occupational Health (FOH)

EAP Documents

Summary of Privacy Act Requirements

Statement of Client Understanding

Authorization to Use or Disclose Confidential Information

Consent to Presence of Translator/Interpreter

Consent to Treatment (minor)

Record Inquiry/Request

FOH EAP Self-Referral Waiver Form

SUMMARY OF PRIVACY ACT REQUIREMENTS

For FOH EAP

Magellan employees and providers who provide services under an EAP for federal employees are required to comply with special federal requirements designed to ensure confidentiality. All records and information obtained from sessions or other client contacts must be kept in a confidential manner in accordance with the Privacy Act of 1974,ⁱ and, where applicable, the federal regulations on confidentiality of drug and alcohol abuse treatment records.ⁱⁱ

The Privacy Act protects all personally identifiable information about individuals (e.g., educational, financial, criminal or employment information as well as health information) that is in a record that can be retrieved by the individual's name or other identifier ("PII").

FOH has determined that the HIPAA privacy rule and the HIPAA security rule ***do not*** apply to the FOH EAP. Providers who are "covered entities" under the HIPAA rules will need to comply with both HIPAA rules and Privacy Act rules when providing services to FOH members. Compliance with HIPAA is not required for providers who are *not* "covered entities" under HIPAA.

This is a summary of the Privacy Act requirements applicable to the FOH EAP, as set forth in the Privacy Act, Privacy Act regulations issued by the Department of Health and Human Services (HHS), and the HHS system of records for the Employee Assistance Program.

Maintenance of records

No record may be maintained unless:

1. It is relevant to EAP functions or is required by law;
2. It is acquired to the greatest extent practicable from the client; and
3. The client is informed of:
 - the authority for the client's providing information for the record (including if providing record is mandatory or voluntary),
 - the purpose for the record,
 - the routine uses for the record, and
 - what effect refusal to provide the information may have.

Because providing the information is not required by law, the client must agree to provide the information.

Magellan and FOH believe that the FOH Client Statement of Understanding is sufficient to satisfy these requirements. If a client desires additional information, you may refer the client to the quality improvement manager for the FOH EAP. The quality improvement manager can be reached at 1-800-274-2477.

Notification to client of existence of record, access by client to record, providing client copy of record

Clients may at any time request notification of, access to, or a copy of a record that pertains to them. You must review the request and, as appropriate, give notice, access or copy, applying the required procedures.

- A request for notification of the existence of a record with PII or for access to PII must be made in-person or in writing. Telephonic requests are not sufficient.
- The written request must (i) specify the records to be searched and the records the requester wants to access and (ii) provide sufficient particulars to enable you to distinguish between

records on clients with similar names. The individual may also request copies of the record or any part of the record.

- The written request must designate a representative to receive the record so that if you conclude that direct access by the client is likely to have an adverse effect on him or her, you can still make the record available. The representative may be a health professional or other responsible individual willing to review the record and inform the client of its contents at the representative's discretion. If you are comfortable discussing the information with the client, you can be the designated representative.
- Before giving a client access to his/her PII or record, you must conduct a clinical review for the likelihood of adverse consequences from giving access to the client or his/her designated representative.
 - ▶ You may only give the client direct access to his/her PII or record if you determine that direct access is not likely to have an adverse effect on the client, other affected persons, the therapeutic relationship, or the treatment services.
 - ▶ If you believe that you are not qualified to determine the effect, or if you determine that direct access is likely to have an adverse effect on the client, other affected persons, the therapeutic relationship, or the treatment services, you must send the PII or record to the designated representative and inform the client in writing that the PII or record has been sent to the designated representative.
 - ▶ If you believe that furnishing the PII or record to the designated representative may result in harm to the client (e.g., if the designated representative has abused the client), you must allow the client to designate an alternative representative.
 - ▶ If you forward the information to the designated representative, you must notify the client that you have done so.
- Unless you personally know the requester, when an individual makes an in-person request for notification of the existence of a record containing PII or for access to PII, the requester must verify his/her identity by presenting both of the following:
 1. At least one piece of tangible identification (e.g., driver's license, passport, alien or voter registration card, or union card). If the requester does not have such ID, the requester must certify in writing that he/she is the person he/she claims to be and understands that a knowing and willful request for or acquisition of records under false pretenses is a criminal offense subject to a \$5,000 fine; and
 2. Further personal verification that parallels the EAP case record (e.g., date of last session, presenting problem, case number, number of sessions).
- When a request is not made in-person (e.g., by mail, fax, email, or similar correspondence), the requester must submit both of the following:
 1. A notarized request that verifies his/her identity *or* written certification that he/she is the person he/she claims to be and understands that a knowing and willful request for or acquisition of records under false pretenses is a criminal offense subject to a \$5,000 fine; and
 2. Further personal verification that parallels the EAP case record (e.g., the date of last session, presenting problem, case number, etc.).
- When a request is made telephonically, the requester must be directed to submit a written request with the verification described above. Because of the difficulty verifying identity by telephone, telephonic requests may not be honored.
- If there will be a delay in responding to the request due to the number of requests being made, breakdown of equipment, shortage of personnel, storage of records in other locations, etc., you must inform the individual making the request and indicate when the request will be granted.

Minors

- A minor may request notification of or access to a medical record pertaining to him/her. The above procedures regarding notification of and access to records apply.
- Parents and guardians who request notification of or access to a minor's medical record must verify their relationship to the minor by presenting the minor's birth certificate, a court order, or other evidence of legal custody.
- Parents and guardians who request notification of or access to a minor's medical record may not be given direct notification of or access to the record. The parent or guardian must designate a health professional (other than a family member) to whom the record will be sent.
 - ▶ You must furnish the record, or notification of the record, to the designated health professional, not the parent or guardian.
 - ▶ If disclosure would constitute an invasion of the minor's privacy, you must alert the health professional and ask the health professional to consider the effect that disclosure would have on the minor in determining whether to make the minor's medical record available to the parent or guardian. Your response to the parent or guardian must be substantially as follows:

I have completed processing your request for notification of or access to _____'s (name of minor) medical records. Please be informed that if any medical record were found pertaining to that individual, they have been sent to your designated health professional.

- In each case where a minor's medical record is sent to a health professional, reasonable efforts must be made to inform the minor.

Correction or amendment of records

A client may request that his/her record be corrected or amended if the client believes the record is not accurate, timely, complete, or relevant.

- The client must make the request in writing, unless the request is made in-person and the correction or amendment is made at that time. A written request must specify the following:
 1. That the information comes from the FOH EAP system of records;
 2. The particular record he/she is seeking to correct or amend;
 3. Whether he/she is seeking an addition to or a deletion or substitution of the record, and;
 4. The reasons for the request.
- You must acknowledge or complete processing of the request within 10 working days of receipt.
- If you agree that the record is not accurate, timely, or complete (based on a preponderance of the evidence), you must correct or amend the record.
 - ▶ If the record is not relevant or necessary to accomplish the function for which it was provided or is maintained (i.e., to provide counseling services, etc.), the record must be deleted -- whether or not it is accurate.
 - ▶ Whatever you determine, the client must be informed in writing of the correction, amendment, or deletion.
 - ▶ If an accounting was made of prior disclosures, all recipients of the record must be informed of the corrective action.

- If you do not agree that the record should be corrected or amended, you must inform the client in writing of your refusal to correct or amend and of the right to appeal your refusal to the U.S. Assistant Secretary of Health.
 - The client may be directed to send the appeal request to the FOH EAP by contacting the quality improvement manager. The quality improvement manager can be reached at 1-800-274-2477.
 - If the appeal is denied by the assistant secretary, the client may submit a statement of disagreement to you. In that case, you must note in the record that it is disputed and you must furnish the statement of disagreement along with the record whenever the record is disclosed in the future.
 - In addition, if an accounting was made of prior disclosures of the record, all prior recipients of the record must be provided a copy of the statement of disagreement, as well as any written statement of the assistant secretary's reasons for denying the client's appeal.

- If a record is governed by another agency, the request to correct or amend the record must be forwarded to that agency for processing. The client must be informed in writing of the referral to the agency.

Disclosure of records

Except as provided below, no disclosure of personally identifiable information may be made without the written consent of the client.

- Certain disclosures may be made without the consent of the client.
 1. To your employees, Magellan employees, and FOH employees who have a legitimate need for the information in order to perform their job duties. This would include disclosures for purposes of coordination of care, monitoring progress, QI, and payment.
 2. For a routine use -- for a purpose that is compatible with the purpose for which the information was collected (i.e., to provide EAP services).
 - Routine uses also include disclosure to a federal agency in connection with issuance of a security clearance, response to a subpoena from a federal agency with authority to subpoena records of another agency, record destruction, EXCEPT, if the case relates to substance abuse, under the federal regulations on confidentiality of alcohol and drug abuse records, 42 CFR, Part 2, the PII may not be disclosed without the client's authorization or a court order.
 3. To the subject, but only on written request and designation of a representative, as described above under "Notification to client of record, access by client to record, providing client copy of record."
 4. To an individual, on a showing of compelling circumstances affecting the health or safety of any individual. Notice of such a disclosure must be sent to the client's last known address. (Magellan and FOH believe that this exception encompasses child/adult abuse reporting and duty to warn/protect.)
 5. Disclosures required under the Freedom of Information Act.
 6. Pursuant to a court order.

- Consent to disclosure
 - The client's consent to disclosure must specify the following:
 1. The person or entity to whom the record may be disclosed;
 2. Which record may be disclosed; and,
 3. Where applicable, the time frame during which the record may be disclosed (e.g., "during the school year," "while I am out of the country," "as long as my EAP case remains open").

- ▶ The FOH Client Statement of Understanding may be sufficient if the particular type of disclosure is addressed in the Statement of Understanding. Otherwise, the FOH authorization for use or disclosure of confidential information or any authorization form designed to comply with the federal regulations on confidentiality of drug and alcohol treatment records is required.
- Before giving information to the client or a third party, the identity of the requester must be verified, as described above in connection with access to record.
- Consent of a parent or a guardian is not sufficient for disclosure of a minor's medical record if state law allows minors to consent to treatment.

Accounting of disclosures

A client may request access to an accounting of disclosures at any time.

- You must keep track all disclosures of a record other than:
 1. Disclosures with the client's written consent
 2. Disclosure to your employee, a Magellan employee, or an FOH employee, as needed for the performance of his/her responsibilities
- The tracking must include the following information:
 1. The date, nature, and purpose of each disclosure; and
 2. The name and address of the person or entity to whom the disclosure is made.
- The tracking must be retained for the longer of five years or for so long as you retain the EAP case record.
- The client request for an accounting (i.e., a copy of your tracking) and the response to the request must comply with the requirements described above for responding to requests for notification of or access to records, including the requirements pertaining to minors.

Copying fees

A copying fee may be charged where an individual requests that a copy be made of a record.

- No fees may be charged for any of the following:
 1. a search of records, regardless of whether the search is manual, mechanical, or electronic;
 2. for a copy required in order to provide access to the record (i.e., the printing of an electronic record required in order to create a copy for the client); or
 3. for a medical record made available to a designated representative or a designated health professional.
- The maximum fees are as follows:
 1. Photocopying records - \$0.10 per page.
 2. Copying of records not amenable to photocopying (e.g., punch cards or magnetic tapes) -- actual cost, determined on a case-by-case basis.
 3. No charge if the total charges for copying are \$ 25.00 or less.

Standards of conduct

HHS holds the EAP and EAP providers to high standards of conduct in handling records subject to the Privacy Act.

➤ **DO**

- ▶ Be informed of your responsibilities under the Privacy Act.
- ▶ Be alert to possible misuses of records and report to your Magellan EAP care manager any potential or actual violation of the Privacy Act.
- ▶ Make disclosures of records within your office or to Magellan only to an employee who has a legitimate need to know in the course of his/her official duties.
- ▶ Maintain records as accurately as practicable.

➤ **DON'T**

- ▶ Disclose personally identifiable information in any form except (1) with the consent or at the request of the client; or (2) where its disclosure is permitted.
- ▶ Permit unauthorized individuals to be present in areas where FOH EAP records are maintained.
- ▶ Knowingly or willfully take action that might subject you, Magellan, or FOH to liability under the Privacy Act.
- ▶ Establish any record system without making reasonable effort to assure that the system can be maintained in accordance with the Privacy Act, the HHS regulation, and the HHS Notice of EAP System of Records.

ⁱ 5 USC §552a

ⁱⁱ 42 CFR Part 2

Federal Occupational Health (FOH) Employee Assistance Program (EAP)
Statement of Client Understanding

We know that it may be a difficult decision to see an EAP counselor for the first time. Employees are sometimes concerned about the privacy of what they say. We would like to assure you that, except as described in this document, your EAP record is confidential and explain some of the laws and regulations that protect it. Your EAP counselors are committed to upholding high professional standards in maintaining your privacy.

The principal purpose of maintaining information about you is to document your assessment, intervention and follow-up activities. The information is also used to monitor your progress. The information provided by you is voluntary. However, if you limit the information you share, the EAP counselor's ability to provide full services may be affected.

The Privacy Act covers all EAP records. If after discussing the Privacy Act with your counselor you have additional questions, please feel free to discuss them with an attorney. In addition, EAP records of clients with alcohol and drug problems are subject to extra restrictions described in the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations. In some cases, EAP records may also be subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA). Generally, these laws and regulations prohibit EAP staff from sharing any information about you outside the EAP.

There are some situations, however, when information about you can be released. We are required by law and regulation to inform you about these situations. We can disclose information:

1. when you consent to disclosure in writing; or
2. when disclosure is required by a court order or subpoena; or
3. when information is disclosed to medical personnel in a medical emergency or when the disclosure is made in a non-identifiable form to qualified personnel for research, audit or program evaluation; or
4. when information is disclosed to a private firm, individual, or group providing EAP functions contractually. The contractor is required to maintain all confidentiality safeguards and surrender these records to the EAP Administrator at the time of contract termination; or
5. to the Department of Justice or other lawyers for defending your agency, the EAP, and/or their employees in litigation when information relating to your use of the EAP is necessary and relevant to the lawsuit.; or
6. to an agency, upon request for certain law enforcement purposes, when requested by the head of the agency; or
7. in response to a subpoena or discovery request when (i) Magellan receives assurance that reasonable efforts have been made to obtain a qualified protective order protecting the information or (ii) the subpoena is from the Inspector General; or
8. upon request from the appropriate agency official, in order to confirm that you have made or kept EAP appointments during regular duty hours (no other information will be given without proper consent.); or
9. to the appropriate management official under your agency's Drug Free Workplace Program, if you are tested and receive a verified positive drug test result; or
10. if you pose a danger to yourself or others, or threaten to commit a serious crime. This disclosure could involve law enforcement and, in the case of harm to others, the potential victim. No other information about your use of the EAP will be disclosed; or
11. if you provide any information which would lead us to suspect child abuse or neglect (or in some states elder and spouse abuse). In these cases, we are required to report that information under State law to appropriate State or local authorities.

Your EAP counselor may ask you to sign an authorization to disclose information, particularly when HIPAA applies.

The authority for maintenance of your record is 5 U.S.C. 7361, 7362, 7901, 7904, and 44 U.S.C. 3101. See also HHS Personnel Instruction 792-2. Violation of the Federal laws and regulations by the EAP is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

In addition to the other information contained in the document, the following sections are applicable to components of the United States Coast Guard and the Air Force Materiel Command.

Active Duty Coast Guard: The Coast Guard, in its mandate to provide a safe work/community environment, does not tolerate disruptive, violent or threatening behavior on the part of its membership. This mandate extends to Coast Guard communities and homes and includes suicidal thoughts, homicidal thoughts, child abuse/neglect, spouse abuse, parent abuse, elder abuse/neglect and sibling abuse. While the Coast Guard's Work-Life (W/L) programs, specifically the Employee Assistance Program and Family Advocacy Program, are not punitive in nature, when this type of behavior is encountered, or when a Coast Guard member is referred due to any of the above, the EAP counselor will disclose this information to the cognizant Coast Guard W/L staff. This staff includes the Employee Assistance Program Coordinator (EAPC), Family Advocacy Specialist (FAS), and/or the Family Resource Specialist (FRS). Unless the facts clearly indicate that disciplinary action is warranted by the command, the purpose of disclosure to the Coast Guard W/L staff is to ensure that they have the information required to provide appropriate services and case management.

Air Force Materiel Command Civilian Employees and Active Duty Members (includes activated Reserve and Guard members): Abuse of alcohol or other substances will be reported to the unit security manager of AFMC civilian employees who are on PRP or flying status, carry weapons or hold a position requiring a SCI clearance. Suspected domestic abuse, child abuse/neglect, or elder/parent abuse/neglect by an active duty military member or a civilian employee living with an active duty member will also be reported to the base Family Advocacy Program per DOD Instructions and Service regulations and instructions.

Please check and initial your status:

- Flying Status _____
- SCI Clearance _____
- PRP _____
- Weapon Bearing _____
- Active duty military member _____
- Civilian employee living with active duty military member _____
- None of these categories _____

I understand that the initial EAP assessment is free of charge. If short-term counseling is determined to be clinically appropriate, the EAP counselor or local affiliate will also provide this service at no cost to me. However, I acknowledge and understand that Federal Occupational Health (FOH), its EAP Contractors, and its customer organizations are not responsible for the treatment costs and/or services for which I may be referred beyond the EAP counselor or local affiliate counselor. I understand that it is my sole responsibility to pay for all such services including all charges not covered by insurance plans.

I have read the foregoing Statement of Client Understanding, and I understand and agree to it.

Client Name _____
(Please Print)

Client Signature _____ Date _____

EAP Counselor _____ Date _____

If you have questions or comments, please consult your counselor or call the EAP 24-hour toll-free telephone 1-800-222-0364 or TTY 1-888-262-7848

**U.S. Department of Health and Human Services
Federal Occupational Health
Employee Assistance Program
Authorization to Use or Disclose Confidential Information**

Section 1. Whose information will be disclosed?

Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YYYY) / /
Street Address	City	State	Zip Code Phone Number

I hereby authorize the use or disclosure of confidential information about the individual named above.

I am:	<input type="checkbox"/>	the individual named above (complete Section 8 below to sign this form)
	<input type="checkbox"/>	a personal representative because the client is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who will disclose information about the individual?

The following person(s) or entity may use or disclose the information:

Name (a person, a class of persons like "counselor who saw me in August 2007," or an organization)	Phone Number (if known)
Street Address (if known)	City, State and Zip Code (if known)

Section 3. Who will receive information about the individual?

The information may be disclosed to:

Name (a person, a class of persons like "family members residing with me", or an organization)	Phone Number (if known)
Street Address (if known)	City, State and Zip Code (if known)

Section 4. What information about the individual will be disclosed?

Only the following information (<i>Client must INITIAL each item to be disclosed</i>)	
<input type="checkbox"/> Whether I am participating in the EAP <input type="checkbox"/> Attendance records <input type="checkbox"/> Progress report on my EAP counseling <input type="checkbox"/> Prognosis <input type="checkbox"/> Drug/alcohol history <input type="checkbox"/> Results of mental status examination <input type="checkbox"/> Other (describe information to be disclosed & any restrictions): _____	<input type="checkbox"/> Whether I am complying with EAP recommendations <input type="checkbox"/> Closing summary <input type="checkbox"/> EAP recommendations <input type="checkbox"/> EAP intervention summary <input type="checkbox"/> Diagnosis/assessment

Section 5. What is the purpose of the disclosure?

- To verify whether I am participating in and complying with EAP recommendations (**Formal referral**)
- To enable the EAP to make a referral for treatment
- To enable the EAP to verify my attendance at an EAP session on-the-clock
- At my request
- Other (*please describe*): _____

Section 6. What is the expiration date or event? (*check one*)

This authorization must expire within 1 year, on either a specific date or upon a specific event. Please choose either:

- the following expiration date (no more than 1 year from today): ____/____/____
- the following specific event (needs to happen within 1 year): _____

Section 7. Important Rights and Other Required Statements You Should Know

- ❖ You can revoke this authorization at any time by writing FOH EAP, MO-22 P.O. Box 2124, Maryland Heights MO 63043. If you revoke this authorization, the revocation will not apply to information that has already been used or disclosed.
- ❖ The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- ❖ You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- ❖ This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- ❖ You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to FOH EAP, MO-22 P.O. Box 2124, Maryland Heights MO 63043.
- ❖ If you have any questions about anything on this form, or how to fill it out, we can help. Please call 1-800-222-0364.

Section 8. Signature of the Individual

I am the individual I claim to be and I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense under the Privacy Act, subject to a \$5000 fine.

Signature _____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature _____ Date (required) _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare. You may be asked to provide us with the relevant legal document giving you this authority.
Relationship to the individual (required): _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which is protected by federal and may also be protected by state law. If the records relate to alcohol and drug abuse patient records, you are prohibited by 42 CFR Part 2 from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person named above, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CONSENT TO PRESENCE OF TRANSLATOR/INTERPRETER

I, _____, wish to receive assessment and/or brief counseling services through the Federal Occupational Health Employee Assistance Program (FOH EAP).

- I am hearing-impaired, and/or
- The language I speak is _____

I wish a translator/interpreter who communicates in _____ to be present during counseling sessions with my counselor so that I may communicate effectively with my counselor.

Translator/interpreter I want:

- Member of my family Other

Name: _____

Relationship: _____

Telephone Number: _____

- Translator/interpreter selected by FOH EAP

I understand that by electing to have a translator/interpreter present, the translator/interpreter will be privy to all information that I share with my counselor.

I understand that I may revoke my consent to the presence of the translator/interpreter at any time except to the extent that action has been taken in reliance upon it. However, I acknowledge that such revocation may comprise the quality of subsequent counseling.

Date: _____

Signature

Date: _____

Witness

Acknowledgement of Confidentiality Obligations by Translator/Interpreter

I, _____, agree to serve as a translator/interpreter during counseling sessions for the above client. I understand that any and all information relating to the counseling, including the identity of the client, is confidential information and that federal and state law prohibits me from re-disclosing the information without written authorization of the client.

Date: _____

Signature

Federal Occupational Health (FOH)
Employee Assistance Program (EAP)

**CONSENT TO TREATMENT
(MINOR)**

Name of minor: _____

Age: _____ years, birth date: _____

I, _____, am the legal custodian of the above-named minor.
Please print

Please check one.

- I have full legal authority to consent to treatment of the minor without obtaining consent or approval of another person.
- I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person.

I hereby authorize the FOH EAP to provide counseling to the minor in connection with substance abuse, mental health and/or other personal problems.

Parent or Legal Guardian

Date: _____

Witness: _____

**Federal Occupational Health
Employee Assistance Program
Record Inquiry/Request**

Type of Request: Notification of record Access to record Copy of record

Requested By:

Name: _____

Address: _____

Home telephone: ____ _____ Work/Cell phone: ____ _____

Client Information:

Client name (if different from above): _____

Client address (if different from above): _____

Date of birth: ____/____/____ Is the client a minor? Yes* No

Home telephone: (_ _ _) _ _ _ - _ _ _ _

EAP Information:

Approximate date(s) of EAP use:

Records relating to calls to the EAP toll-free number 1-800-222-0364

In person counselor: Name of counselor: _____

Location of Counseling: _____
Address (If known) City State

Information about request:

Need for Disclosure:

Designated Representative to review record [Health professional or other responsible person; this can be the EAP counselor if that is client's choice. For minors, it must be a health professional]:

Designated Representative's
address: _____

Address (If known) City State ZIP

Signature of Requester:

I certify that I am the person identified above. I understand that knowingly and willfully requesting and obtaining a record about an individual under false pretenses is a criminal offense subject to a \$5,000 fine.

Signature : _____

Date: _____

Note: Federal regulations protect the privacy of minors. Parents and legal guardians may not be given direct access to their records by the EAP. Instead, records requested by parents and legal guardians are sent to a designated health professional.

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FEDERAL OCCUPATIONAL HEALTH
EMPLOYEE ASSISTANCE PROGRAM
WAIVER OF REFERRAL FORM

I have been receiving services from _____ (“Provider”) through the Employee Assistance Program (EAP) provided by Federal Occupational Health (FOH).

I understand that it is my provider’s judgment that my issues cannot be resolved through the brief counseling or other services available through the EAP, and that I therefore need treatment beyond the services available through the EAP.

I understand that the FOH EAP has the capability to refer me to an appropriate clinician in my community to furnish ongoing treatment. The provider has offered two other referral resources, _____ and _____. However, I choose to see the provider in his/her private practice for ongoing treatment. I understand that I will be responsible for payment for all services provided by the provider _____, 20____, that services after that date will no longer be FOH EAP covered services, and that if I desire reimbursement under my benefit plan, I am responsible for determining whether or not the treatment rendered by the provider will be covered under the benefit plan. The FOH EAP does not guarantee that such treatment will be covered under my benefit plan.

I also understand that the provider is solely responsible for my treatment from the date specified in the previous paragraph and that the FOH EAP has no connection whatsoever with the treatment I will receive from the provider as of that date.

I give my permission for a copy of this form to be sent to the FOH EAP.

FOH EAP Case/Mat authorization

Witness

Date

Print name of client

Signature of client

FOH EAP
Revised March 15, 2008