

Federal Occupational Health (FOH) Employee Assistance Program

Introduction

Federal Occupational Health (FOH), an agency within the Department of Health and Human Services (HHS) and Program Support Center (PSC), contracts with Magellan to provide an EAP to civilian employees for a consortium of government agencies such as the Transportation Safety Administration, US Citizenship and Immigration Services, and US Department of Agriculture. Some agencies have a special name for their EAP. Some programs may have different 800 numbers and specially branded program materials. Clients may not be aware that their EAP is part of FOH or Magellan.

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. Direct questions about the FOH EAP or the contents of this section of this appendix to Magellan's FOH EAP staff at: **1-800-222-0364**.

FOH EAP Service Center
Magellan Healthcare, Inc.
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 for any reason including fitness-for-duty or requests for job changes or time off. Federal agencies require physician documentation regarding fitness-for-duty, time off, etc.
- You are not to contact or respond to 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. Notes confirming attendance should be written directly to the client, not to the agency or supervisor.

Dual-Client Relationship

Within the consortium of FOH customer agencies, there are civilian 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 a client's supervisor, union representative or any other 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.

FOH EAP Components

Self Referrals

Employees of covered federal agencies and their 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 upon disclosure of a personal issue by the employee 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 consultant or care manager after the first session; you will also need to report attendance to the consultant 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 Response (CIR)

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 a 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.

If Magellan requests you to conduct a CIR service, fee arrangements will be made at that time by a Magellan representative. A Magellan FOH staff member will consult with you regarding

the response prior to your going onsite. When responding to a Federal building or site, please bring photo ID and allow extra time for security screenings.

Health and Wellness Presentations

FOH provides EAP orientations to employees and supervisors. In addition, a variety of health and wellness presentations are offered; presentations are not trainings. 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.

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 household members. Clients with urgent situations (cases involving risk of harm, abuse, or other circumstances in which a client 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 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 FOH EAP consultants and care managers are master's level or higher licensed clinicians who provide consult 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 when a case involves clinical risk or substance abuse.

Documentation

Beginning with the first client contact, you are to maintain a record of contacts with and/or relating to each client, with the most recent information at the front of the record. Notes are to contain identifying information only as reasonably needed for your services. You are responsible for ensuring that every client record is legible, orderly, accurate, and complete. Every action you take must be documented, as well as on-going progress notes; each note must contain your signature.

Upon each case assignment, you will receive access to the online EAP registration packet 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 SOU is specific for the account; use the FOH SOU for all FOH cases** (included in this appendix). *Note:* every adult present in EAP sessions 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 EAP services and limits of confidentiality. If the client has a question that you cannot answer, refer the client to the FOH EAP National Service Center (1-800-222-0364).
- 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.

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.
- You may submit for payment for FOH EAP cases online or fax to 1-888-656-5032.
- If you wish to mail the EASI Form to the FOH EAP, the billing address is: Attn: FOH EAP Provider Coordinator, Magellan Healthcare, 14100 Magellan Plaza, Mail Stop MO22, Maryland Heights, MO 63043.
- Billing on CMS forms, Magellan's Treatment Request Forms, or any other 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.
- Billing and payment issues are not to be discussed with clients. Questions about billing or payment should be directed 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 after the first session, 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. There are a variety of session models available for agencies to choose for their employees – 1 to 3 and 1 to 6 session models are the most common. The EAP referral sheet 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 your initial assessment suggests that care beyond the EAP sessions 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 to the client's health benefit plan or other community resource as soon as it is clinically appropriate.
- You may make referrals, as necessary, to appropriate resources within the community. You are required 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, you may offer yourself as a referral source for longer-term counseling to an EAP client **only if** the client is offered a choice of two other mental health providers in addition to yourself. You must have the client sign the Waiver of Referral Form and retain a copy in the case record (form included in this appendix).

Care Management

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.

Services Not Available Under the FOH EAP

If the client requests these or similar services that are outside the scope of the EAP, 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

- You may receive a subpoena in connection with an EAP case. 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 valid court order from a court of competent jurisdiction is signed by a judge. Please refer to your own legal counsel for guidance when in receipt of a subpoena or court order or contact the Magellan FOH EAP care manager. Magellan does NOT provide legal advice about how you should respond to a subpoena or court order you receive.
- 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, please refer to your own legal counsel for guidance, or contact the Magellan FOH EAP care manager.
 - 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 Waiver Referral 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 applicable to providers and Privacy Act rules applicable to counselees when providing services to FOH members. Please refer to your own legal counsel for guidance.

This is a summary of the Privacy Act requirements applicable to the FOH EAP, as set forth in (i) the Privacy Act, (ii) Privacy Act regulations issued by the Department of Health and Human Services (HHS), and (iii) the HHS notice of Privacy Act System of Records for the EAP.

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.

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 from the client may designate a representative to receive the record. The representative may be a health professional or family member or attorney or other individual specifically named by the client to receive the record.
- If you believe, before giving a client access to his/her PII or record, that there may be adverse consequences from giving access to the client or his/her designated representative, you must conduct a clinical review for the likelihood of such consequences.
 - Give the client direct access to his/her PII or record only 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.
 - Contact the Magellan FOH EAP care manager if you have any questions.
- 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 should verify their relationship to the minor as you deem appropriate.
- Parents and guardians who request notification of or access to a minor's medical record may be given direct notification of or access to the record, unless applicable state law allows the minor to restrict access to the record. Please refer to your own legal counsel for guidance, or contact the Magellan FOH EAP care manager

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.

Disclosure of records

Except as provided below, no disclosure of PII 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.
 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 Statement of Client Understanding may be sufficient if the particular type of disclosure is addressed in the Statement of Client 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. Disclosures 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.

ⁱ 5 USC §552a

ⁱⁱ 42 CFR Part 2

Behavioral Health Services Employee Assistance Program STATEMENT OF UNDERSTANDING

Welcome to Federal Occupational Health (FOH) Employee Assistance Program (EAP). The following provides an overview of the confidentiality parameters of the program.

Records are maintained on EAP participation, as authorized under 5 U.S.C. 7361, 7362, 7901, 7904, and 44 U.S.C. 3101. All EAP records are bound by the provisions of the Privacy Act (5 U.S.C. 7361, 7362, 7901, 7904, and 44 U.S.C. 3101), and the Department of Health and Human Service Personnel Instruction 792-2.

EAP staff is committed to maintaining the privacy of clients, and upholding the highest standards of professional conduct. The EAP maintains information about a client to document clinical activities, and to monitor a client's progress. Information provided is always voluntary and at the client's discretion.

Under certain situations, FOH is required or permitted by law to disclose information. These situations include:

1. When you consent to disclosure in writing.
2. When disclosure is required by a court order or subpoena.
3. When information is disclosed to medical personnel in a medical emergency or when the disclosure is made to qualified personnel for research, audit or program evaluation.
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.
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.
6. In response to a subpoena or discovery request when (a) the FOH EAP receives assurance that reasonable efforts have been made to obtain a qualified protective order protecting the information or (b) the subpoena is from the Inspector General.
7. 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).
8. 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.
9. 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.
10. If you provide any information which would lead the counselor to suspect child abuse or neglect (or in some states elder and spouse abuse). In these cases, the FOH EAP is required to report that information under State law to appropriate State or local authorities.

Behavioral Health Services
Employee Assistance Program
STATEMENT OF UNDERSTANDING



If you have questions after discussing the Privacy Act with your counselor, please discuss them with an attorney.

I understand that my agency and Federal Occupational Health (FOH) and FOH EAP contractors are not responsible for the treatment costs and/or services for which I may be referred beyond the EAP 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 our National EAP Service Center at the number below.

Federal Occupational Health
Employee Assistance Program
(800) 222-0364 | TTY: (888) 262-7848
FOH4You.com

**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: the individual named above (complete Section 8 below to sign this form)
 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 (*Client must INITIAL each item to be disclosed*)

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

Section 5. What is the purpose of the disclosure?

<input type="checkbox"/>	To verify whether I am participating in and complying with EAP recommendations (Formal referral)
<input type="checkbox"/>	To enable the EAP to make a referral for treatment
<input type="checkbox"/>	To enable the EAP to verify my attendance at an EAP session on-the-clock
<input type="checkbox"/>	At my request
<input type="checkbox"/>	Other <i>(please describe)</i> : _____

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:

<input type="checkbox"/>	the following expiration date (no more than 1 year from today): ____/____/____
<input type="checkbox"/>	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: _____

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

The original version of this material was developed by Magellan Healthcare for the Department of Health and Human Services through contract number HHSP23320075300DC with Federal Occupational Health Services.

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 number

Witness

Date

Print name of client

Signature of client