

Affiliate Manual



Aurora Health Care[®]

Aurora Employee Assistance Program



Aurora Employee Assistance Program

Affiliate Manual Receipt

Aurora Employee Assistance Program ("Aurora EAP") requires a signature indicating that the Affiliate has received and read the Affiliate Manual and understands the procedures the Affiliate must comply with. Affiliates may access the Affiliate Manual on Aurora EAP's website.

Affiliates should understand that if any questions arise, they should contact the appropriate staff at Aurora EAP for immediate assistance. This receipt should be returned with the signed Affiliate EAP Services Agreement.

"I, _____, have received a copy of the Affiliate Manual. I have read and understand the Affiliate Manual and agree that my activities as an Affiliate shall be bound by, and I shall comply with, the Affiliate Manual."

Affiliate Representative Signature

Date

Name

Title

Clinic Name

Return this receipt to:
EAP Network Coordinator
Aurora EAP
2636 Eastern Avenue
Plymouth, WI 53073

Aurora Employee Assistance Program

Affiliate Manual

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I. INTRODUCTION

Aurora Employee Assistance Program ("Aurora EAP") recognizes that our success is partially dependent on our Affiliate network. This manual was developed to inform and educate Affiliates about the business and philosophy of Aurora EAP, to train and assist Affiliates in the EAP Consultation process and to clarify Affiliate obligations and Aurora EAP's policies, procedures and expectations.

Part of Aurora EAP's orientation and training of Affiliates includes a review of the Affiliate Manual. The Affiliate Manual is available on our website at www.aurora.org/eapaffiliates or may be sent by mail to Affiliates upon request.

The Affiliate Manual, as modified from time to time, is considered to be a part of the Affiliate EAP Services Agreement between Aurora EAP and the Affiliate. Aurora EAP expects that Affiliates understand and accept the policies and responsibilities associated with their role as outlined in the Affiliate Manual. It is required that our Affiliates review the Affiliate Manual and return the signed Affiliate Manual Receipt (located on page 2) with the Affiliate EAP Services Agreement.

The primary contact for Affiliates is Aurora EAP's Network Coordinator, who can be reached at (920) 449-7722 or (888) 389-3299. Aurora EAP staff is also available to answer general questions at (414) 760-5401 or (800) 236-3231, Monday through Friday, 8 a.m. to 5:00 p.m. (Central Standard Time).

II. DEFINITIONS

The following terms, when used in the Affiliate Manual and/ or Affiliate EAP Services Agreement, shall have the following meanings:

Affiliate- means a provider who has entered into an Affiliate EAP Services Agreement with Aurora EAP to provide EAP Services.

Affiliate EAP Services Agreement- means the agreement between Aurora EAP and an Affiliate setting forth the terms and conditions of the Affiliate's provision of EAP Services.

Client- means eligible employees, and/ or household members of an eligible employee, of an Employer who purchased an employee assistance program from Aurora EAP. Clients are entitled to receive EAP Services in accordance with Aurora EAP's contract with such Clients' Employer.

DOT Assessment- means a mandatory assessment for safety-sensitive transportation employees as determined by federal regulations and the Department of Transportation.

EAP Consultation- means either of the following: Basic EAP Consultation (or Assessment) or Supervisory EAP Assessment.

EAP Services- means any one or any combination of the services listed in Section VI of this Affiliate Manual.

Employee- means an employee of an Employer as defined below.

Employer- means an employer who purchased an employee assistance program from Aurora EAP.

III. WHO WE ARE:

AURORA EMPLOYEE ASSISTANCE PROGRAM

Welcome to the Aurora EAP Affiliate network! Our Affiliate Manual provides information Affiliates need to successfully partner with us and to effectively serve our Employers and Clients.

Aurora EAP has been in business since 1983, making us one of the oldest and largest employee assistance programs in the Midwest, serving Employers of all sizes throughout the U.S. We were awarded top scores by the Council on Accreditation of Services for Families and Children, during its most recent review, attesting to our success at meeting the highest national standards for non-profit service providers.

Currently Aurora EAP serves approximately 300 Employers. We provide services to Employers within the Milwaukee and Southeast Wisconsin area. We also have a network of more than 400 affiliates throughout North America to serve our Employers who have expanded on a national scale.

Aurora EAP provides a wide range of services to Employers. We strive to deliver confidential, quality services to help Clients successfully meet home and workplace challenges. Each Employer determines which services will best meet the needs of Clients. These services may include:

- EAP Consultation
- Supervisory EAP Assessment
- DOT Assessment
- Short-Term Problem Resolution
- Onsite Employer Services
- Specialized Work-life Services (including Child Care and Elder Care Information and Referral, Budget and Debt Management Services, and Legal Consultation)

We are pleased to have you join our team in providing services to our Clients and Employers.

Thank you for bringing your expertise and commitment to our team.

IV. HOW WE PARTNER WITH AFFILIATES

The following individuals are Affiliate contacts for coordinating services with Aurora EAP. Their roles and responsibilities are described below.

EAP Network Coordinator – The EAP Network Coordinator is the primary contact for all Affiliates, to answer questions on Aurora’s general procedures or our paperwork. Call the EAP Network Coordinator at any time regarding contracting concerns or procedural questions. The EAP Network Coordinator also coordinates the credentialing of Affiliates, and must be contacted when new counselors in an Affiliate's office would like to become Affiliates.

Contact our Network Coordinator at (920) 449-7722 or (888) 389-3299.

Intake Department – The Intake Department either connects the Client to the Affiliate's office or instructs the Client to call the Affiliate's office to schedule an EAP Consultation. The Intake Department then faxes the Intake Information page (containing Client information) to the Affiliates. Call the Intake Department if there is any question regarding the Client.

Contact our Intake Department at (414) 760-5401 or (800) 236-3231.

Account Executive - The Account Executive works directly with Employers and coordinates EAP Supervisory Assessments. For EAP Supervisory Assessments, Affiliates must call the Account Executive immediately following the initial Supervisory EAP Assessment session.

Contact our Account Executives at (414) 760-5400 or (800) 511-4804.

V. EAP STANDARDS

A. Professional Qualifications

Affiliates must complete Aurora EAP's Individual and Clinic Applications (see Appendix A), as applicable, and submit documentation to support the following qualifications:

1. Degree

- A Master's degree in a behavioral science from an accredited program of study.
- In some cases Aurora EAP may make an exception to the Master's degree requirement and consider a provider as meeting the degree requirement if the provider is:
 1. Certified by the Employee Assistance Certification Commission ("EACC") as a Certified Employee Assistance Professional ("CEAP");
 2. Certified as an addictions counselor by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission ("NAADAC"); or
 3. Certified by the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse ("ICRC").

This is a rare exception to be made at the sole discretion of Aurora EAP for special substance abuse and D.O.T. cases only.

2. State Certification/ Licensure

- State certification/licensure in the Affiliate's state of practice, as applicable.

3. Experience/ Skills

A minimum of two (2) years supervised post-degree experience in a clinical setting, and experience with a broad range of clinical work including:

- Diagnosis and treatment of a combination of mental health and substance abuse problems and
- Training and experience in brief problem solving counseling.

4. Professional Liability Insurance

All affiliates providing EAP Services must have and maintain professional liability insurance with limits in accordance with their Affiliate EAP Services Agreement.

B. Professional and Ethical Guidelines

Confidentiality

Confidentiality is the cornerstone of EAP Services. Affiliates must obtain the Aurora EAP Release of Information form (see Appendix D, Form 275) prior to disclosing information to a third party, except in the case of threat of harm to self/others or suspected abuse of a child or adult. Affiliates do not need to obtain the Release of Information form to disclose any information to Aurora EAP.

Employee assistance programs are governed by federal and state statutes and regulations which mandate reporting of situations when a person poses a risk of grave physical or emotional danger to themselves or another person or organization. It is the Affiliate's duty to adhere to the legal and professional standards/ guidelines of reporting as designated by their profession. Please contact the Intake Department on any high-risk case where consultation is needed, or when disclosing information without a release of information. The Intake Department will connect Affiliates with the appropriate member of our clinical staff for immediate assistance.

The Dual Roles in an EAP

Aurora EAP always balances the interest of two parties: (1) the Client who is seen for EAP Consultation and (2) the Employer that makes the EAP Services available to Clients. With these dual roles, conflicts of interest may arise. Aurora EAP attempts to balance this by separating the role of the Affiliate and the Account Executive. If at any time, however, an Affiliate believes she or he is encountering a conflict of interest or is unsure of what steps need to be taken while dealing with these complex relationships, the Affiliate should contact the Network Coordinator. Above all, Affiliates must refrain from any activities that may be harmful to the Client or the Employer.

Ongoing Training and Professional Membership

Affiliates are asked to join our Affiliate network based upon training, experience and clinical expertise. Affiliates are also expected to be knowledgeable and remain up-to-date regarding EAP Services, current research and practice.

The Employee Assistance Professionals Association, Inc. ("EAPA") certifies eligible professionals and offers individual and group memberships. EAPA offers monthly meetings, regular publications and workshops for networking and resource development. Call Aurora EAP for more information or contact EAPA directly at (703) 387-1000, or on its website at www.eapassn.org.

Representation of the EAP

Affiliates provide visibility of Aurora EAP to Clients, Employers, and the community. When Affiliates are providing EAP Services to a Client or Employer and/or are making a referral, Affiliates are representing Aurora EAP.

It is very important that Affiliates explain the nature and scope of EAP Services to Clients. When Clients leave the Affiliate's office they often talk with co-workers, managers and family members about the experience and the appropriateness of the referral. Therefore, it is vital that Clients leave with a sense that they have accessed a highly professional and confidential resource that has met their needs.

As an affiliate for the Aurora EAP, you play an important role in supporting the reputation of the employee assistance field and the Aurora EAP. Caution and due regard should be used when making any public statement about Aurora EAP or our EAP Services. All standards of confidentiality and Client privacy rights must be carefully maintained.

VI. AFFILIATE EAP SERVICES

Please Note: Affiliates should refer to their Affiliate EAP Services Agreement to determine which of the following EAP Services they have agreed to provide.

A. Basic EAP Consultation

The Basic EAP Consultation is the primary service Affiliates provide to Clients. The majority of Clients have contacted Aurora EAP on a voluntary basis for assistance with a variety of problems. The following are some key guidelines for a Basic EAP Consultation.

- The Intake Department will identify the Client as a Basic EAP Consultation when calling the Affiliate. Affiliates will also be faxed the Client Data Form page, authorizing the number of sessions within the bottom section (see Appendix B).
- Focus of the Basic EAP Consultation is to determine whether the Client's problems can be resolved with a consultation, or will require additional help through a referral.
- Usually consists of one session of approximately one (1) hour in length, during which the Affiliate listens to the Client's concerns and may offer a variety of suggestions, such as a referral to a support group, community resources or counseling. Sometimes the Affiliate's professional expertise in the Consultation may be all that is needed to assist the client.
- May also include referring a Client back to Aurora EAP for one of the Aurora EAP's specialized Work-life Services described in Section VII (B).
- If the referral is to a mental health or alcohol/ drug counselor, the Affiliate will refer to a provider covered by the client's health benefits whenever possible (see Section VII (C)).
- Affiliates are working as an extension of Aurora EAP, and therefore do not need Clients to sign a release of information form prior to contacting Aurora EAP. Our Release of Information form (see Appendix D, Form 275) is only needed when Affiliates' Consultation information will be released to a third party, such as a treatment provider or the Client's Employer (see Supervisory EAP Assessment, Section VI (B)).
- Affiliates must complete all required Aurora EAP Consultation paperwork as part of the EAP Consultation, in order to receive payment for this EAP Service (see Section VIII (C) and Appendix D).

- Remember an EAP Consultation is distinct from a mental health assessment. The Aurora EAP aims to provide a broad consultation in order to provide a range of referral and assistance options to Clients. The following chart is a summary of the differences between an EAP Consultation and a mental health assessment:

EAP CONSULTATION VS. MENTAL HEALTH ASSESSMENT

	<u>EAP</u>	<u>Mental Health</u>
Role	Comprehensive Consultation, referral, problem-solving	Mental health/AODA assessment and ongoing treatment
Functions	Identify problem(s) Assess severity Refer	Diagnose Assess severity Treat
Focus	Broad General	Specific In-depth
Contract	Dual Contract Limited Relationship Work through other professionals Ombudsman Governed by EAP contract and ethics	Individual Contract Ongoing Relationship Provide treatment Advocate Governed by mental health laws

B. Supervisory EAP Assessments

Supervisors and/ or human resources personnel of Employers may refer Employees to Aurora EAP due to a problem in the workplace, such as job performance problems or a violation of Employer policies (e.g. testing positive for drugs or alcohol). The Employee may be required by their Employer to comply with a Supervisory EAP Assessment as a part of the disciplinary process.

The Intake Department will identify the Employee as a Supervisory EAP Assessment when calling the Affiliate. Affiliates will also be faxed the Client Data Form page, along with two additional pages which contain details about the Employee: (1) the Supervisory EAP Assessment Information page and (2) the Release of Information to Employer (see Appendix C). It is the Affiliate's responsibility to complete a thorough Supervisory EAP Assessment and contact the Aurora EAP Account Executive immediately following this session to report compliance.

Supervisors and/ or human resources personnel may classify the Supervisory EAP Assessment as one of the following types (this will be indicated on the Supervisory EAP Assessment Information page):

Formal

This is a Supervisory EAP Assessment based on job performance problems such as absenteeism, conflict with others, etc. The Employee is not required to comply with the Supervisory EAP Assessment, though noncompliance may have an impact on the Employee's job depending on the supervisor's expectations for the Employee.

Mandatory

These Supervisory EAP Assessments are reserved for terminable offenses such as violating the Employer's substance abuse policy or any other infraction that warrants a last chance agreement. The Employee must attend the Supervisory EAP Assessment and comply with all recommendations.

Supervisory EAP Assessment Guidelines

Affiliates should keep the following guidelines/ reminders in mind:

- Two (2) additional pages will be faxed to Affiliates along with the Intake Information page (see samples in Appendix C):
 - (1) Supervisory EAP Assessment Information page, which contains details about job performance issues (indicating if the referral is formal or mandatory), and
 - (2) Release of Information for Supervisory EAP Assessments

- **It is critical that Affiliates have the Employee sign the faxed Release of Information to Employer at the first appointment.** This form, when signed by the Employee, allows the Account Executive to communicate compliance to the Employee's Employer. Affiliates should inform the client that the Account Executive will not share any details of the content of the Supervisory EAP Assessment with the Employer. The information shared with the Employer is determined by the scope of the release. In the event that an Employee refuses to sign the release, Affiliates should notify the Account Executive. The Account Executive may then only report that s/he has not been given a release authorizing disclosure of the Employee's information to the Employer.
- Affiliates should look for the name of the Account Executive on the Supervisory EAP Assessment Information page. **It is very important that Affiliates make contact with the Account Executive immediately following each Supervisory EAP Assessment session.**
- While Affiliates handle the Employee aspect of our business, the Account Executives handle all of our Employer communication. Please remember that the Account Executive is your contact person for all Supervisory EAP Assessments, and will make direct contact with the Employer. **Affiliates should have no contact with the Employer.**
- Please remember that the Affiliate's role in a Supervisory EAP Assessment is to assist the Employee to improve work performance based on the Employer's expectations as stated on the Supervisory EAP Assessment Information page. Aurora EAP and our Affiliates have a dual responsibility to Employees and Employers. It is very important that Affiliates maintain awareness of both Employees and Employers and do nothing to jeopardize either relationship (see Professional and Ethical Guidelines Section V (B) for more detail).
- Affiliates must complete all required EAP Consultation paperwork in order to receive payment for this EAP Service (see Section VIII (C) and Appendices C and D).

C. DOT Assessments

The U.S. Department of Transportation ("DOT") monitors safety-sensitive transportation Employees and requires mandatory evaluation of Employees who are suspected of substance abuse or violate a substance abuse policy. Many of Aurora EAP's Employers have Employees who are covered under these regulations. Often an Employee will fail a drug screen and be referred to the Aurora EAP as both a mandatory Supervisory EAP Assessment and a DOT Assessment (subject to DOT regulations).

A DOT Assessment, as defined in DOT regulation 49 C.F.R. Part 40, must be completed by a Substance Abuse Professional ("SAP") as defined below. Affiliates who are interested in providing this service to Employees on behalf of Aurora EAP must be determined by Aurora EAP to meet the following criteria: (1) SAP requirements listed below, (2) experience as a SAP and (3) familiarity with the DOT regulations. If an Affiliate meets these criteria and wishes to provide DOT Assessments to Employees, a separate rate will be agreed upon for this EAP Service in the Affiliate EAP Services Agreement.

The Intake Department will identify the Employees as a DOT Assessment when calling the Affiliate. Affiliates will also be faxed the Intake Information page, along with two additional pages which contain details about the Employee: (1) the Supervisory EAP Assessment Information page and (2) the Release of Information to Employer (see Appendix C).

Substance Abuse Professional ("SAP") Qualifications

DOT regulation 49 C.F.R. Part 40 defines the SAP as a person who evaluates employees who have violated a DOT drug and alcohol regulation and makes recommendations concerning education, treatment, follow-up testing, and aftercare.

Required Credentials:

- Licensed physician (Doctor of Medicine or Osteopathy);
- Licensed or certified social worker;
- Licensed or certified psychologist;
- Licensed or certified employee assistance professional; or
- Alcohol and drug counselor certified by the National Association of Alcoholism and Drug Abuse Counselors Certification Commission ("NAADAC") or by the International Certification Reciprocity Consortium/ Alcohol and Other Drug Abuse ("ICRC").

Required background/ training

- Must have knowledge of, and clinical experience in, the diagnosis and treatment of substance abuse-related disorders.
- Must have an understanding of how their role relates to the special responsibilities Employers have for ensuring the safety of the traveling public.

- Must be knowledgeable about the pertinent DOT agency regulations (49 C.F.R. Part 40).
- Must have received qualification training in DOT, which meets the requirements of 49 C.F.R. Part 40, Section 281(c).

DOT Assessment Guidelines

- Affiliates who complete a DOT Assessment must comply with DOT regulations and SAP requirements as detailed in DOT Regulation 49 C.F.R., Part 40.
- At the initial DOT Assessment session, Affiliates must obtain the Employee's signed Release of Information for Supervisory EAP Assessments. This form, when signed by the Employee, allows the Account Executive to communicate with the Employee's Employer. The Account Executive will have information to help Affiliates coordinate a plan for the Employee and can also help coordinate the Employee's return to work.
- DOT reporting must be done on the Affiliate's own letterhead, and submitted directly to the Designated Employer Representative ("DER") at the Employer. Affiliates should send a copy of this report to the Aurora EAP, along with the Client Data Form (Form 265) and Invoice (Form 282), within thirty (30) days of the initial DOT Assessment (see Section VIII (C) for paperwork details and Appendix D).

D. Short-Term Problem Resolution ("Short-Term")

What is Short-Term Problem Resolution?

Short-Term Problem Resolution ("Short-Term") is an additional EAP service purchased by some Employers, which includes a limited number of additional sessions (determined by the Employer) beyond the EAP Consultation.

- The purpose of Short-Term is to assist the Client in solving a personal or work-related problem that may affect their productivity or general life satisfaction. It also may be used to motivate the Client to follow-through with a referral for ongoing treatment.
- The Affiliate's role in Short-Term is to provide clarification, education, support and motivation to the Client. Short-Term differs from therapy in that it is a brief EAP Service, which may be all some Clients need to resolve a concern.
- This option allows the Client to receive needed assistance without accessing their health benefits, when the problem appears to be short-term and can potentially be resolved within the identified number of sessions. The Client Data Form page faxed to Affiliates will indicate the number of authorized sessions available for the particular Client.
- For more serious or long-term problems, the Client should be immediately referred to the appropriate mental health provider rather than to Short-Term. This is to avoid a situation in which the Client engages with the Affiliate, and then has to begin service with a different provider covered by the Client's health benefits.
- If the EAP Consultation indicates a need for mental health treatment rather than Short-Term, Affiliates should explain their rationale to the Client, and refer the Client directly to a provider covered by the Client's health benefits. It is the Affiliate's responsibility to assist the Client in accessing health benefits when a referral to mental health or substance abuse treatment is indicated. This would include referring within a provider network, if necessary (see Section VII (C)).

When to Use Short-Term

- The problem is specific, well defined, and agreed upon by both the Client and Affiliate.
- The Client is self-directed and has the ability and desire to follow-through on suggestions.
- The Client is currently functioning at work, in relationships and in the community.
- The Client has a support system that is present or can be activated.

- The Client demonstrates willingness to follow-through with adjunctive, supportive community services.
- The Client identifies workable solutions in the first appointment.
- The Client expresses the desire for Short-Term versus other services, demonstrates the ability to understand the scope and limitations of Short-Term and agrees to receive Short-Term.

Important Reminders

- There is no need for a diagnosis or CPT code, as this is not therapy. Your payment will come from Aurora EAP, based on prior approval of these sessions and your submission of our completed paperwork (see EAP Affiliate Guidelines, Section VIII (C) and Appendix D).

For any questions, please call our Network Coordinator at (920) 449-7722 or (888) 389-3299.

E. Onsite Employer Services

Our Account Executive will be notified of any onsite needs of our Employers. If the Aurora EAP is not near the Employer's site, the Aurora EAP may ask an Affiliate to provide the Onsite Employer Service. Affiliates may decide at the time of entering into the Affiliate EAP Services Agreement if their office is interested in contracting to provide onsite EAP Services for our Employers.

Affiliates will be provided with guidance and materials as needed for all Onsite Employer Services. Affiliates should contact the Account Executive at any time for consultation and assistance.

Types of Services

Crisis Response

Following an Employer crisis, it is important for the Aurora EAP to provide immediate assistance to the Employer according to their needs/ wishes. There are two response types:

- **Crisis Intervention:** Includes any onsite services which occur immediately after an Employer crisis.
- **Critical Incident Stress Debriefing ("CISD"):** This service generally occurs within forty-eight (48) to seventy-two (72) hours after a traumatic event. Moreover, CISDs have a formal structure, which requires two (2) individuals who are trained to deliver this service.

Training

Aurora EAP provides many training opportunities for Employers, such as:

- **Employee orientation:** Orienting Employees to Aurora EAP and our EAP services.
- **Supervisor training:** Aurora EAP offers a full menu of training opportunities for supervisors and managers, including a fundamental supervisor training and many additional topics.
- **Personal enrichment:** Training designed for Employees to address the most prevalent personal and workplace issues and to give Employees the skills and information they need to cope effectively.

For Supervisor and Personal enrichment trainings only, Affiliates are required to distribute the Training Evaluation form to all attendees of the training. The Training Evaluation forms must be returned to the Network Coordinator with the Invoice (see Appendix E).

Promotional event

At times, Employers may request Aurora EAP to be onsite for promotional events such as health and benefit fairs. If the Employer requests to include Aurora EAP promotional materials (such as wallet cards or brochures), the Account Executive will supply this to the Affiliate.

Onsite Consultation

Human Resources or Management personnel may request an Aurora EAP representative be present at any number of meetings between Employers and Employees. If this is requested, the Account Executive will contact the Affiliate with the details of this Employer's request.

Onsite Employer Services Guidelines

When Affiliates provide these services to our Employers, the following guidelines will apply:

- These services are usually scheduled in advance, so Affiliates should have adequate time to plan and prepare, except of course in the event of a crisis or traumatic event.
- In the event of a workplace crisis, the Account Executive on-call will be notified immediately of the need for crisis intervention services. **Affiliates who have contracted to provide these services must be reachable and able to respond twenty-four (24) hours a day, seven (7) days a week in accordance with the terms of their Affiliate EAP Services Agreement.**
- To initiate billing, Affiliates must submit our Invoice (see Appendix E). All designated areas for Onsite Employer Services should be complete.
- The completed Invoice must be submitted within thirty (30) days of the Affiliate's provision of Onsite Employer Services to ensure prompt payment.
- For trainings, Affiliates must also send in the Training Evaluation forms completed by Employee participants.

VII. MAKING A REFERRAL

Clients who are in need of resources beyond EAP Services should be provided with a referral for additional services. Referrals are meant to direct Clients to the proper level of care, the most cost-effective provider, and additional resources as needed. This may include a community referral, referral back to Aurora EAP for one of our Specialized Work-life Services, or a treatment referral. The following offers more detail about the types of referrals an Affiliate might make, along with important reminders.

A. Community Resources

- May include a referral to such resources as a free support group, AA meetings, an educational program, etc.
- Aurora EAP encourages our Affiliates to think about Clients' needs in a broad way, which may mean offering a variety of referral options.

B. Aurora EAP Specialized Work-life Services

These services are free to Clients as part of their Employer's EAP contract. Affiliates are encouraged to refer Clients back to Aurora EAP for these services. Clients must call **Aurora EAP's Intake Department at (800) 236-3231** for any of these services:

Child Care and Elder Care

- Information and referral to assist Clients caring for children or an aging relative.

Budget and Debt Management

- Consultation and referral for money management and credit problems.

Legal Consultation

- Consultation with, and/ or referral to a lawyer.

C. Treatment Referral

When Affiliates determine the Client would benefit from mental health or substance abuse treatment, it is the Affiliate's responsibility to assist the Client. This may include connecting the client with outpatient services, intensive outpatient services, partial hospitalization, or inpatient psychiatric care.

Affiliates must check the Client's health benefits prior to making a referral. Whenever possible, Affiliates should attempt to refer Clients to those providers/ facilities that are covered by such Clients' health benefits plan. Affiliates are strongly discouraged from referring Clients to themselves for treatment (see Self-referrals below). Affiliates may contact Aurora EAP at any time for assistance in making a referral.

It is essential for Affiliates to complete the Treatment Referral section of the Case Closing Form (Form 276, see Appendix D). Some Employers have an incentive built into their health plan to encourage the use of EAP Services, and your referral gives the Client access to the highest level of mental health benefits. When Aurora EAP receives the Affiliate's completed paperwork containing the referral information, we notify the Client's health plan administrator of the referral.

Following are a few additional guidelines Affiliates must keep in mind:

Self-referrals

- A self-referral is defined as an Affiliate continuing to see an Aurora EAP Client beyond the approved EAP Services, (i.e. for mental health treatment through the Client's health benefits).
- It is important to Aurora EAP that Clients receive the help they need in their EAP Consultation, whether it is through a few sessions with the Affiliate or a treatment referral. Ideally, the Client should be able to contact the Affiliate as a resource person who can assist the Client if the treatment referral does not work out to the Client's satisfaction. This role is not possible when Affiliates self-refer.
- We strongly discourage self-referring, however we understand that this may occur occasionally in geographical areas with limited providers or in the case of a strong preference by the Client. This practice should be an exception.
- In the event the Affiliate needs to self-refer, the Affiliate must first make sure s/he is covered by the Client's health benefits and also offer the Client two (2) other options outside of the Affiliate's agency/ clinic (if possible).
- The Affiliate must have the Client sign our Freedom of Choice Affidavit (Form 281, see Appendix D), indicating that s/he has been given other choices, yet wishes to remain with the Affiliate for treatment. This form also reiterates the fact that EAP Services are ending, and treatment services (which the Client is financially responsible for) are beginning. This form must be explained to the Client and signed by both the Client and the Affiliate. The Client should also be given a copy of this form.

Behavioral Health Management

- Aurora EAP provides Behavioral Health Management for some Employers. With these Employers, Aurora EAP manages mental health and substance abuse treatment services for Clients' health benefits. This includes pre-authorization and ongoing review of outpatient and inpatient care.

- For Behavioral Health Management Clients only, a provisional diagnosis is required on the Case Closing Form (Form 276). Affiliates should indicate one of the following general diagnostic categories:

Alcohol Abuse, Anxiety Disorder NOS, Cocaine Related Disorder NOS, Depressive Disorder NOS, Disorder of Infancy, Childhood, or Adolescence NOS, Disruptive Behavior Disorder NOS, Other Substance Abuse, or Psychotic Disorder NOS.

- Referrals for treatment must be made within the Aurora EAP Preferred Provider Organization Network ("PPO"). **Note this is not the same as the Aurora Health Network. Do not refer outside of the PPO.**
- Contact the Network Coordinator for help in finding PPO providers and if you have any questions regarding our Behavioral Health Management services.
- Self-referrals are not appropriate in most cases. Contact the Network Coordinator for consultation as needed (see above, Self-referrals).

VIII. EAP AFFILIATE GUIDELINES

A. Aurora EAP Clients

- Clients must contact the Aurora EAP to utilize EAP Services. If appropriate, our Intake Department will schedule the Client with an in-person EAP Consultation.
- The Intake Department will either connect the Client by phone to the Affiliate or will call to alert the Affiliate that the Client will be contacting them to schedule an EAP Consultation.
- If a Client contacts an Affiliate's office directly, without first contacting Aurora EAP, Affiliates must refer the Client back to Aurora EAP before seeing the Client. **There will be no guarantee of payment for sessions held without the approval of the Aurora EAP.**
- A Client Paperwork Packet, consisting of the Client Data Form with number of Authorized Sessions and other required EAP paperwork, will be faxed to the Affiliate after the Client contacts Aurora EAP.

B. Appointments/ Availability

- Affiliates must inform Aurora EAP of their regular business hours, which must include some evening appointment availability. Affiliates are responsible for notifying the EAP Network Coordinator if these hours of availability change.
- Affiliates must offer Clients an appointment within two (2) working days of the Client's initial call to the Affiliate. If the Client declines that appointment, Affiliates should offer another appointment at a time convenient to both the Affiliate and Client.
- Affiliates must advise Aurora EAP of after hours coverage for Client emergencies.
- Affiliates must designate and identify a person ("Contact Person") as the liaison between the Affiliate and Aurora EAP who is available during the Affiliate's regular business hours, except during Affiliate holidays disclosed to Aurora EAP. This person is responsible for ensuring the procedures in this Affiliate Manual are followed and that all the Affiliate's counselors are aware of Aurora EAP's procedures.
- Affiliates must notify Aurora EAP immediately of a change in such Contact Person.

C. Paperwork

- **All applicable paperwork must be received by the Aurora EAP within thirty (30) days of each session and meet Aurora EAP's quality standards to ensure payment (see Section VI).** This may include (see Appendix D):

265- Client Data Form

273- Statement of Understanding Form

276- Case Closing Summary Form

282- Invoice

261- Outpatient Referral Letter (if applicable)

281- Freedom of Choice Affidavit (if applicable)

275- General Release of Information (if applicable)

- Paperwork may be copied from the Affiliate Manual or printed off of our website at www.aurora.org/eapaffiliates. Affiliates must always use the most current version of the paperwork, which can be found on our website.
- The Paperwork Instructions (see Appendix D) provide clear instructions for completing our forms and should be used as a reference.
- Call our **Network Coordinator at (920) 449-7722 or (888) 389-3299** with any questions about our forms.
- In the event that a release of information form is needed, Affiliates must use Aurora EAP's version of this form (General Release of Information, see Appendix D).

D. Billing

- Except as provided below, to initiate payment for EAP Services, Affiliates must submit all applicable paperwork (see Section VI and Appendix D). To ensure payment, paperwork must be submitted **within thirty (30) days** of each EAP Service provided.
- To initiate payment for Onsite Employer Services, Affiliates must submit our completed Invoice within thirty (30) days of the Onsite EAP Service (see Appendix E).
- **The Aurora EAP will only pay for EAP Services that have been approved.**
- The Aurora EAP shall pay Affiliates for EAP Services within sixty (60) days of the receipt of all completed paperwork. Payment is contingent upon completion of all Affiliate responsibilities in connection with this Affiliate Manual and the Affiliate EAP Services Agreement, including, but not limited to, submission of all required paperwork.
- Affiliates' fees for EAP Services are set forth in the Affiliate EAP Services Agreement between Affiliate and Aurora EAP.

- Aurora EAP will not reimburse Affiliates for phone contact with Clients or appointments missed or cancelled by the Client. Call the EAP Network Coordinator if you have any questions about this or have a difficult or unusual circumstance you would like us to consider.
- Affiliates shall not submit an Invoice to and/or seek payment from the Client, the Client's health plan or the Client's Employer for (1) EAP Services, (2) phone contact with the Client or (3) missed or cancelled appointments by Client.
- Fees for services provided by Affiliates beyond the contracted EAP Services are the sole responsibility of the Client. Affiliates must assist Clients in obtaining the best benefit possible from such Client's health plans (see Making a Referral, Section VII).
- To receive payment, Affiliates must only use Aurora EAP's paperwork. **Affiliates' office forms or other billing forms will not be accepted.**

**Questions about payment or billing may be directed to our Network Coordinator at
(920) 449-7722 or (888) 389-3299**

IX. APPENDICES

A. APPENDIX A

Applications

Affiliate Application- Clinic

Clinic Information

Clinic Name: _____ Tax ID: _____

Clinic Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Clinic Email: _____ Internet accessible to staff? Yes No

Billing Address: _____

City, State, Zip: _____

*Please attach a list of any additional locations (include staff names)

Contact Person (see Affiliate Manual for detail): _____

Insurance:

Insurance Carrier: _____ *Attach certificate of liability insurance

Expiration Date: _____ Coverage Limits: _____

EAP Information:

1. Number of years clinic has been providing EAP Services: _____
2. Number of Masters Level staff available to provide EAP Services: _____
3. Number of Masters Level Certified AODA staff available to provide EAP Services: _____
4. Number of staff who are Certified Employee Assistance Professionals (CEAP): _____
5. Number of staff qualified to provide DOT assessments as a Substance Abuse Professional (as defined by DOT regulation- 49 C.F.R. Part 40): _____
6. Do you have staff available to conduct an Onsite Crisis Response if requested? Yes No
7. Do you have staff available to conduct an Onsite Training if requested? Yes No
8. Do you have staff available to conduct an Onsite Promotional Event if requested? Yes No
9. Do you have staff available to conduct an Onsite Consultation if requested? Yes No
10. Do you have staff available to provide EAP Services in other languages? Yes No

If yes, please list: _____

11. Please describe the ethnicity of the counselors in your clinic.

12. Is your office space handicap accessible: Yes No

Please describe any limitations: _____

13. In routine situations, are staff available to see Clients within two (2) working days: Yes No
14. In urgent situations, are staff available to see Clients within twenty-four (24) hours: Yes No
15. In emergencies, are staff available to see Clients on a same-day basis: Yes No

16. Please list regular clinic hours:

Monday: _____ Saturday: _____

Tuesday: _____ Sunday: _____

Wednesday: _____

Thursday: _____

Friday: _____

17. Are staff ever available outside of these regular hours? Yes No

If yes, list when exceptions are made: _____

18. Describe after hours back-up and telephone coverage.

19. Please add anything else that you feel is important to know about your EAP services or staff.

I have received and read the Affiliate Manual (www.aurora.org/eapaffiliates) and understand the procedures the Affiliate must comply with. I agree that the Clinic's activities as an Affiliate shall be bound by, and shall comply with, the Affiliate Manual.

Signed: _____		
Title: _____	Date: _____	

Please send completed applications to:
 EAP Network Coordination
 Aurora Employee Assistance Program
 4067 N. 92nd Street
 Wauwatosa, WI 53222
 Phone 888-389-3299
 Fax 414-760-5418

Affiliate Application- Individual

Name: _____ Credentials: _____
 Last First MI

Social Security #: _____ DOB: _____ Sex: Male Female

Clinic Name: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Email: _____

Experience:

Mental Health AODA CEAP Trauma/ Grief Other _____

1. Number of years providing counseling/ therapy? _____
2. Number of years providing EAP Assessments? _____
3. Are you qualified to provide SAP (substance abuse professional) assessments for the Department of Transportation? Yes No
4. Can you provide EAP orientations/ trainings? Yes No
5. Can you provide CISD/ crisis interventions? Yes No
6. Languages other than English? _____

You MUST include copies of the following:

- State Certification(s)/License(s), Resumé AND Malpractice Insurance and additional supporting material, if needed.

Statement of Professional Ethics and Conduct

Are you or have you been subject to the following (*If you answer yes to any of the following, please attach a complete written explanation.*):

1. Professional liability insurance cancellation in the past five (5) years? Yes No
2. Suspension as a Medicare or Medicaid Provider? Yes No
3. State licensing investigations or actions? Yes No
4. Any certifications ever revoked, limited, or suspended? Yes No
5. Clinical privileges ever been suspended, limited, or withdrawn for cause? Yes No
6. Conviction of a felony, or moral or ethical crime? Yes No
7. Any addictions, chronic illness, or physical/psychological limitations that would impair your ability to practice your specialty? Yes No
8. Dismissed or received disciplinary action for reasons of sexual misconduct? Yes No
9. Have you ever voluntarily given up privileges, registration, certification or licensure to practice therapy, or agreed to restrict your practice in lieu of or to avoid formal action? Yes No

I affirm that all information contained in this application is complete and accurate to the best of my knowledge. My signature below indicates that I adhere to the Employee Assistance Professionals Association ("EAPA") code of ethics and EAPA standards regarding confidentiality and record keeping.

I hereby give Aurora Employee Assistance Program the right to seek and obtain a report from any licensing or certification committee to which I belong pertaining to any violation found or any case opened against me.

I also give permission to Aurora Employee Assistance Program to request appropriate information regarding the action(s) named above from the relevant regulatory body, professional association, agency or court, and Aurora Employee Assistance Program to communicate with all people listed as my endorsers, teachers, supervisors, or superiors as shall be deemed necessary.

I have received and read the Affiliate Manual (www.aurora.org/eapaffiliates) and understand the procedures the Affiliate must comply with. I agree that my activities as an Affiliate shall be bound by, and I shall comply with, the Affiliate Manual.

Signature: _____ Date: _____

Send completed applications to: EAP Network Coordination, Aurora EAP, 4067 N. 92nd Street; Wauwatosa, WI 53222 or fax to 414-760-5418.

B. APPENDIX B

Client Data Form Information page- Sample

CLIENT DATA FORM

Please review this form for accuracy. Make corrections as needed and initial all changes.

Client Name: _____ Client ID#: _____

D.O.B.: ____/____/____ Case Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I can be reached at: (Please circle your preferred contact number.)

Home Phone: (_____) _____

Can we contact you at this number: Yes No
Can a message be left: Yes No
Can we identify ourselves as EAP: Yes No

Work Phone: (_____) _____

Can we contact you at this number: Yes No
Can a message be left: Yes No
Can we identify ourselves as EAP: Yes No

Cell Phone: (_____) _____

Can we contact you at this number: Yes No
Can a message be left: Yes No
Can we identify ourselves as EAP: Yes No

Other Phone: (_____) _____

Can we contact you at this number: Yes No
Can a message be left: Yes No
Can we identify ourselves as EAP: Yes No

May we contact you by Email to follow-up? If yes, Email Address: _____

May we contact you by U.S. mail to follow-up? Yes No

Relationship to Employee: Self Spouse/ Partner Child Household Member

Employer Name: _____ Site Name: _____

Length of Employment: Less than 1 year 1 year to 5 years More than 5 years

How did you hear about EAP? Co-worker EAP Orientation/Training Family Member Human Resources
 Insurance Promotional Materials Repeat Client Supervisor Union Web Site

I verify that the information provided above is accurate and complete. I have made any necessary corrections and initialed any changes.

Client Signature _____

Date _____

APPOINTMENT AUTHORIZATION INFORMATION

Number of Authorized Sessions: _____

Appointment Date: ____/____/____

Appointment Time: _____

Counselor: _____

Clinic: _____

Clinic Address: _____

City: _____ State: _____ Zip Code: _____

C. APPENDIX C

Supervisory EAP Assessment pages- Sample

Supervisory EAP Assessment Information

Referral Date: 07/08/2011

Account Executive

Mike Rupsch

To The Assessment Counselor / Affiliate:

The following information is provided to help you assess an Employee who has been referred to Aurora EAP due to job performance problems. You may refer to this information when meeting with the Employee. Please complete the Release of Information for Supervisory EAP Assessments and contact the Account Executive regarding the outcome of the assessment. Only the Account Executive may contact the Employer.

If you have any questions, please call the Account Executive (see above) at 800.544.4804.

Employee/ Account Information

Name	John Client	Employer	Sample Company
Job Title	Nurse	Site	Sample Site
Work Phone	(414) 555-2222	Requested by	Ann Manager
Home Phone	(414) 555-1111	Dept/Div	Nursing
		Job title	Nurse Manager

Job Performance Problem(s)

Reasons For Referral

Complaints from customers or coworkers; Workplace conflicts

Employee is having frequent conflicts with coworkers and is verbally hostile toward coworkers and managers. Recent incident in which employee was rude to a patient who complained.

Discipline

Date Problem First Observed: 05/16/2011

Number of Events:

Expectations

Consent for Disclosure Scope:

- Attendance at EAP Assessment
- Agreement to follow through with recommendations.
- Compliance with EAP Recommendations.
- Reports of progress and treatment

Employer Expectations: Employee must attend at least 2 EAP Assessment sessions, sign ROI, and comply with recommendations.

Release of Information to Employer

I, _____, _____
(Name of Client) (Date of Birth)

(Address) (City) (State) (Zip)

authorize Aurora Employee Assistance Program to release information confirming my participation in the EAP assessment process to:

(Employer Representative/Company)

PURPOSE: To report compliance following a Supervisory Referral and EAP Assessment.

Information to be disclosed: Both verbal and written information

- scheduling and attendance of EAP assessment(s), or failure to do so
- date(s) of EAP assessment(s)
- agreement to follow through with EAP recommendations
- failure to comply with EAP recommendations
- compliance with treatment recommendations

Dates of information to be disclosed: From _____ To _____

Expiration Date: This Release is good until the following date(s)/events: _____. If no date or event is specified, this Release will expire one (1) year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS RELEASE: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I am also aware that I may revoke this Authorization by notifying the Aurora EAP in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

I have had an opportunity to review and understand the content of this Release. By signing this Release, I am confirming that it accurately reflects my wishes.

Signature of Client

Date

Signature of Legal Representative

Date

If signed by a LEGAL REPRESENTATIVE, complete the following:

1. Individual is: a minor legally incompetent or incapacitated deceased
2. Legal authority: parent* legal guardian next of kin/executor of deceased activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child

D. APPENDIX D

EAP Assessment Paperwork

CLIENT DATA FORM

Please review this form for accuracy. Make corrections as needed and initial all changes.

Client Name: _____ Client ID#: _____

D.O.B.: ____/____/____ Case Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I can be reached at: (Please circle your preferred contact number.)

Home Phone: (_____) _____

Can we contact you at this number: Yes No
Can a message be left: Yes No
Can we identify ourselves as EAP: Yes No

Work Phone: (_____) _____

Can we contact you at this number: Yes No
Can a message be left: Yes No
Can we identify ourselves as EAP: Yes No

Cell Phone: (_____) _____

Can we contact you at this number: Yes No
Can a message be left: Yes No
Can we identify ourselves as EAP: Yes No

Other Phone: (_____) _____

Can we contact you at this number: Yes No
Can a message be left: Yes No
Can we identify ourselves as EAP: Yes No

May we contact you by Email to follow-up? If yes, Email Address: _____

May we contact you by U.S. mail to follow-up? Yes No

Relationship to Employee: Self Spouse/ Partner Child Household Member

Employer Name: _____ Site Name: _____

Length of Employment: Less than 1 year 1 year to 5 years More than 5 years

How did you hear about EAP? Co-worker EAP Orientation/Training Family Member Human Resources
 Insurance Promotional Materials Repeat Client Supervisor Union Web Site

I verify that the information provided above is accurate and complete. I have made any necessary corrections and initialed any changes.

Client Signature _____

Date _____

APPOINTMENT AUTHORIZATION INFORMATION

Number of Authorized Sessions: _____

Appointment Date: ____/____/____

Appointment Time: _____

Counselor: _____

Clinic: _____

Clinic Address: _____

City: _____ State: _____ Zip Code: _____

Paperwork Instructions

Thank you for serving as an Affiliate of Aurora EAP! For each EAP service Affiliates provide, we require our paperwork be completed according to the following standards, and sent back (by fax or mail) to Aurora EAP. The following forms are required for Affiliates to receive payment:

Client Data Form (Form 265): This form is our primary source of data for collecting demographic information and communicating authorized sessions for Affiliates. It is very important that Affiliates make sure all areas of the form are complete. Clients must review the top portion of this form for accuracy and make any changes as necessary. Affiliates should complete the bottom portion of the form with the initial Appointment information. Return this form to Aurora EAP after the initial EAP Consultation.

Statement of Understanding (Form 273): This form must be read by the Client and signed by the Client and Affiliate. Clients should also be given a copy. Please review this form so that you may answer any basic questions Clients might have. Return this form to Aurora EAP after the initial EAP Consultation.

Invoice (Form 282): Please send this form after each EAP Service. Affiliates must fill in their information in the designated area and write in each approved EAP Service as it occurs. This is the only form that should be sent to us after each EAP Service (all other forms may be sent once).

Case Closing Summary (Form 276): This is the summary form for EAP services; therefore the Affiliate should complete this form after completing all EAP Services. Please complete all sections of the form. Once the EAP Consultation is complete, we request that the Affiliate follow-up with the Client to see if everything worked out with the EAP services or referral. No follow-up call is necessary after Short-Term Problem Resolution. Return this form to Aurora EAP with the final Invoice.

****IMPORTANT****: No Shows/ Cancellations: If the Client does not show for their appointment, or cancels and does not wish to reschedule, please notify the Network Coordinator (888-389-3299). Please note that these are not reimbursable.

Additional Forms (For use only when applicable)

Outpatient Referral Letter (Form 261): This form is needed if a client is being referred into mental health treatment outside of EAP services. This letter educates clients about outpatient therapy and what they can do to make the referral process easier for them. **Please give this letter to the client at the point of referral, and document on the Case Closing Summary Form, under the Treatment Referral section, that you have done so.**

Freedom of Choice Affidavit (Form 281): This form is ONLY used if the Affiliate refers the Client to him/herself for mental health treatment outside of EAP Services (under health benefits or private pay). Aurora EAP strongly discourages this practice, however understands that this may occur occasionally in geographic areas with limited providers. Affiliates who self-refer must make sure they are covered by the Client's health benefits, and must offer the Client at least two (2) options outside of the Affiliate's office. Affiliates should explain this form to the Client, and both the Client and Affiliate should sign this form. Clients should be given a copy of this form. Return this form with your final Invoice.

Release of Information: This form is only needed in the event that Affiliates must release information about EAP Services to an outside party such as a treatment provider. This form is not necessary when Affiliates are sharing information with, or returning forms to Aurora EAP.

Notice of Privacy Practices (HIPAA): Please offer this form to all clients. If they are interested in receiving a copy of this 4-page document, you can download it from www.aurora.org/eapaffiliates in the "Helpful Forms" section or call the Network Coordinator (888-389-3299) so it can be faxed to your office.



Employee Assistance Program

Statement of Understanding

Many of us have personal problems that can impact other aspects of our lives. Our families, friends and even work may be negatively affected. Contacting your employee assistance program is a first step in resolving them. Congratulations, you are on your way to making some positive changes for yourself or someone important to you!

Voluntary Participation

Your company has chosen Aurora Employee Assistance Program ("Aurora EAP") to help you and your family to get the right care from the right source. The choice to use Aurora EAP is voluntary and is offered through your employee benefits at no charge to you. Your decision to contact Aurora EAP will not be shared with anyone, including your employer, unless you give consent by signing a release of information form.

EAP Consultation

An EAP consultation is a **confidential** visit with a counselor. It is designed to help you develop a plan that will meet your needs. Your counselor will listen to your concerns, gather facts and information about specific areas of your life, and make recommendations that will help you find the best resources available.

Referrals beyond EAP

Aurora EAP can connect you with community services, legal assistance, support groups, child and elder care resources, and financial counseling. *In some situations, you may receive a referral beyond EAP services for ongoing outpatient mental health or substance abuse counseling. Your health insurance benefits may cover these services in whole or in part; however, you will be responsible for making payment arrangements and may have an out of pocket cost for these services.* Your EAP counselor will be happy to assist you in finding a provider that will best fit your needs and is covered by your health insurance benefit. *Your signature below authorizes Aurora EAP to coordinate your care with your insurance company and with your provider for that purpose.*

Confidentiality

Your contact with Aurora EAP and all information that you share with the counselor is confidential. Your written permission is needed to release information *except* in cases of intent to harm yourself or others; abuse of children, elderly or a vulnerable adult; need to coordinate care with other health care providers or insurance; and/or in cases of danger or harm to your company that includes risk or danger of loss due to your impairment or illegal acts. Our HIPAA Notice of Privacy Practices gives detail about the use and disclosure of your medical information.

**Cancellations

Should you need to cancel your appointment, please notify the EAP at 800-236-3231 at least 24 hours in advance. Failure to do so may delay or disrupt your service.

Customer Satisfaction

Aurora EAP is interested in providing quality services to meet your needs. If you have any concerns or feedback regarding Aurora EAP Services, please contact your counselor or a manager at Aurora EAP immediately.

Notice of Privacy Practices

You hereby acknowledge that Aurora EAP has provided you a copy of its Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA).

I have read and understand this document.

Client Signature: _____

Date: _____

Counselor Signature: _____

Date: _____

Please visit our website for helpful information – www.aurora.org/eap

Case Closing Summary Form

Client Name: _____ D.O.B. _____

PRIMARY PROBLEM TYPE (*Please check ONLY one*):

- | | | | | |
|---|----------------------------------|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Alcohol/Drug | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Child/Family | <input type="checkbox"/> Depression | <input type="checkbox"/> Grief/Trauma |
| <input type="checkbox"/> Marital/Relationship | <input type="checkbox"/> Medical | <input type="checkbox"/> Occupational | <input type="checkbox"/> Other Addictions | <input type="checkbox"/> Stress |

DESCRIPTION OF PROBLEM AND CLIENT:

PERTINENT INFORMATION:

INTERVENTIONS:

FUTURE PLAN:

EAP ASSESSMENT OUTCOME (Decision made at the end of assessment sessions. Check one box only)

- | | | |
|--|--|---|
| EAP ASSESSMENT ONLY | OTHER EAP SERVICES | TREATMENT REFERRAL- <i>specify for all below</i> |
| <input type="checkbox"/> Community Services | <input type="checkbox"/> EAP Short Term Sessions | <input type="checkbox"/> Outpatient (Sliding fee, insurance billable) |
| <input type="checkbox"/> No Further Treatment Required
(EAP 1-3 only) | <input type="checkbox"/> Child Care <input type="checkbox"/> Legal | <input type="checkbox"/> Transitional Care |
| | <input type="checkbox"/> Financial <input type="checkbox"/> Elder Care | <input type="checkbox"/> Inpatient |

TREATMENT REFERRAL: PROVIDER INFORMATION (ONLY if referring into insurance billable treatment)

(Copy this form if additional referrals needed for Behavioral Health Management)

Clinician: _____ Credentials: _____
 Clinic: _____ Phone: _____
 Address: _____
 City: _____ State: _____ Zip: _____

Have you verified that the above provider will be covered by Client's health benefits? Yes No

***IMPORTANT *** Have you provided the client with the Outpatient Referral Letter (Form 261)? Yes No

AUTHORIZATION TYPE - CHECK ONLY ONE. (Complete for Access or Behavioral Health Management companies when there is an outpatient referral. See contract information on the Intake Information sheet)

Company Name _____ Access Behavioral Health Management - Provisional Diagnosis: _____

FOLLOW-UP DATE:
Contact Type: <input type="checkbox"/> Phone <input type="checkbox"/> Letter <input type="checkbox"/> Voice Mail <input type="checkbox"/> EMail <input type="checkbox"/> Client will call back as needed
<i>Chart any follow up in the progress notes.</i>

Signature EAP Assessment Counselor/ Affiliate

Case Closure Date

Invoice

Client Name (or Employer if Onsite Service): _____

<u>Client EAP Services</u>			<u>Onsite Employer Services</u>		
	Date of Service	Date of Invoice Submittal	√ if Case Closed	<u>Service Type</u> (Check one and provide Description)	
Session #1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Crisis Response	
Session #2	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Training	
Session #3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Promotional Event	
Session #4	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Onsite Consultation	
Session #5	_____	_____	<input type="checkbox"/>	# of Employees in Attendance _____ Date _____ Contracted Rate per Hour _____ Onsite Hours _____ Travel Hours _____ Total Hours _____	
Session #6	_____	_____	<input type="checkbox"/>		
Session #7	_____	_____	<input type="checkbox"/>		
Session #8	_____	_____	<input type="checkbox"/>		
Please verify the # of Authorized Sessions at the bottom of Client Data Form .					
D.O.T. Assessment ONLY					
Initial Evaluation Date: _____					
Contracted Case Rate: _____					

EAP Counselor/ Affiliate: _____

Clinic Name: _____

Billing Address: _____

City, State, Zip: _____

Phone Number: _____

Invoice and required paperwork (see box below) must be submitted within thirty (30) days of each EAP Service to:

Aurora Employee Assistance Program
Attn: Billing
FAX: 920-449-7724
2636 Eastern Avenue
Plymouth, WI 53073

Call with any questions: 888-389-3299

Initial Submission:	265- Client Data Form 273- Statement of Understanding 282- Invoice
Ongoing Case:	282- Invoice Only
Case Closed:	276- Case Closing Form 261- Outpatient Referral Letter (if needed) 281- Freedom of Choice (if needed) 282- Invoice



Employee Assistance Program

Thank you for utilizing the Aurora Employee Assistance Program (EAP). I am pleased to have consulted with you as a part of your free, employer-sponsored benefit. I hope that you'll utilize additional EAP services as the need arises.

Based on your current situation, we agreed that outpatient treatment would be most helpful to you. Outpatient treatment is not covered or paid for by the EAP.

Outpatient treatment is often paid through your health insurance benefits. If you use your insurance benefit, you will be responsible for any co-pay or deductible as detailed in your insurance plan. To insure that there is no confusion about any bills or charges for treatment, I'd suggest the following:

Call your insurance company before your first outpatient appointment to:

- Verify what your insurance will cover
- Ask about any deductible or co-pay
- Check the network status of your outpatient provider

Be sure to discuss payment arrangements with your treatment provider in order to understand their billing practices and to ensure that they can answer all of your questions.

If you have any questions or need additional help, please contact me through the Aurora EAP Intake department at 800-236-3231. We look forward to serving you in the future. Thank you for using the Aurora EAP!



Aurora Health Care®

Aurora Employee Assistance Program

Freedom of Choice Affidavit

I _____, verify that I have been offered at least two (2) referral recommendations as part of my EAP consultation and that I have instead decided to seek ongoing assistance through my Aurora EAP counselor’s practice.

My signature below also verifies my understanding that in electing to seek treatment with the counselor named below, I have agreed to use my insurance benefits or pay privately for services. Aurora EAP is no longer responsible for the services provided.

Further, I am aware that no further services provided by this provider are covered by Aurora EAP and that ***I am solely responsible for determining if services are covered under my health plan and payment for any services provided.***

CLIENT
SIGNATURE: _____

DATE: _____

AFFILIATE
SIGNATURE: _____

DATE: _____

General Release of Information

I, _____, _____
(Name of Client) (Date of Birth)

(Address) (City) (State) (Zip)

authorize **Aurora Employee Assistance Program, 4067 N. 92nd St, Wauwatosa, WI, 53222** to release my/client's health information that may contain mental health, developmental disability and/or drug and alcohol abuse treatment information to:

(Name/Address/Program and/or Title)

Check here if authorization is reciprocal (both the disclosing party and the recipient can mutually exchange information below).

Purpose: (Check all that apply)

- To report attendance at EAP assessment
- Treatment planning
- Further follow-up care
- Other (specify) _____

Information to be disclosed: Verbal Written

- Report attendance at EAP assessment & agreement to follow through
- Compliance with treatment recommendations and appointments
- Failure to comply with EAP recommendations
- Reports of progress and treatment
- Other (specify) _____

Dates of information to be disclosed: From _____ To _____

Expiration Date: This Release is good until the following date(s)/events: _____

If no date or event is specified, this Release will expire one (1) year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I am also aware that I may revoke this Authorization by notifying the Aurora EAP in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

I have had an opportunity to review and understand the content of this Release. By signing this Release, I am confirming that it accurately reflects my wishes.

Signature of Client

Date

Signature of Legal Representative

Date

If signed by a LEGAL REPRESENTATIVE, complete the following:

1. Individual is: a minor legally incompetent or incapacitated deceased
2. Legal authority: parent* legal guardian next of kin/executor of deceased activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child

E. APPENDIX E

Onsite Employer Services Paperwork

Company:		Topic:	
Presenter:		Date:	

Overall Program Feedback

	Very Good	Good	Poor	Very Poor
1. The stated goal(s) of this training were met.				
2. Program materials (handouts, videos, etc.) were effective and useful.				
3. I found this training to be beneficial.				
4. I would recommend this training to others.				

Presenter Feedback

1. The presenter(s) demonstrated thorough knowledge of the topic.				
2. The presenter(s) was/were well organized and prepared.				
3. The presenter(s) was/were clear and maintained my interest.				
4. I would attend another training by this presenter.				

Comments:

What was most effective about this training? *(Please comment)*

What suggestions do you have to improve this training? *(Please comment)*

What was most effective about the presenter(s)? *(Please comment)*

What other topics would you like to see presented in the future? *(Please comment)*

Invoice

Client Name (or Employer if Onsite Service): _____

<u>Client EAP Services</u>			<u>Onsite Employer Services</u>		
	Date of Service	Date of Invoice Submittal	√ if Case Closed	<u>Service Type</u> (Check one and provide Description)	
Session #1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Crisis Response	
Session #2	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Training	
Session #3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Promotional Event	
Session #4	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Onsite Consultation	
Session #5	_____	_____	<input type="checkbox"/>	# of Employees in Attendance _____ Date _____ Contracted Rate per Hour _____ Onsite Hours _____ Travel Hours _____ Total Hours _____	
Session #6	_____	_____	<input type="checkbox"/>		
Session #7	_____	_____	<input type="checkbox"/>		
Session #8	_____	_____	<input type="checkbox"/>		
Please verify the # of Authorized Sessions at the bottom of Client Data Form .					
D.O.T. Assessment ONLY					
Initial Evaluation Date: _____					
Contracted Case Rate: _____					

EAP Counselor/ Affiliate: _____

Clinic Name: _____

Billing Address: _____

City, State, Zip: _____

Phone Number: _____

Invoice and required paperwork (see box below) must be submitted within thirty (30) days of each EAP Service to:

Aurora Employee Assistance Program
Attn: Billing
FAX: 920-449-7724
2636 Eastern Avenue
Plymouth, WI 53073

Call with any questions: 888-389-3299

Initial Submission:	265- Client Data Form 273- Statement of Understanding 282- Invoice
Ongoing Case:	282- Invoice Only
Case Closed:	276- Case Closing Form 261- Outpatient Referral Letter (if needed) 281- Freedom of Choice (if needed) 282- Invoice