

Employee Assistance Program - Intake Data

Client Information			
Name (First and Last)			Today's Date
Client is: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Employee and spouse/family		Company Name	Location/Division
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employment Status <input type="checkbox"/> Part time <input type="checkbox"/> Full time	Years with Company
Address			
Home Phone Number		Work Phone Number	Cell Phone Number
Emergency Contact Name/Relationship		Emergency Contact Home Phone	Emergency Contact Other Phone
Source of Referral (If Employee) <input type="checkbox"/> Self <input type="checkbox"/> Supervisor <input type="checkbox"/> Union <input type="checkbox"/> Co-worker/Friend		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Separated <input type="checkbox"/> Living Together <input type="checkbox"/> Other
Ethnic Background <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> African <input type="checkbox"/> American <input type="checkbox"/> Asian/Pacific Is. <input type="checkbox"/> Alaskan/Indian <input type="checkbox"/> Other		Insurance Name and Phone of Insurance _____ Member #: _____ Group #: _____ Insurance Type HMO PPO POS Other	
Statement of Understanding			
<p>The Employee Assistance Program is provided by your employer to help you with issues that affect the quality of your life and your productivity at work. Although clients may be referred to the EAP, the decision to receive services is strictly voluntary. We provide assessment, short term problem resolution and referral services for a wide range of personal and job related problems.</p> <p>Family members may participate in sessions with your permission and/or they may be entitled to separate counseling sessions based on the scope of your EAP benefit. Your BHS EAP counselor will be communicating verbally and in writing with your BHS Care Coordinator to discuss your assessment, progress and referral options. EAP services are free; however, if a problem is assessed to require specialized or extended services beyond those provided by the EAP, a referral will be made to other resources for which you will be financially responsible. In many cases, part of the cost for additional counseling sessions will be covered by your health insurance. I hereby acknowledge and understand that BHS, its prime contractors, and its customer organizations are not responsible for the treatment costs and/or services for which I may be referred to beyond the EAP counselor or local provider counselor.</p> <p>Employees' job security and promotional opportunities will not be affected because of seeking EAP assistance. However, participation in EAP services does not prevent your employer from following the company's standard disciplinary procedures regarding unacceptable employee work performance or behavior.</p> <p>Your attendance at the EAP and the information you share is protected against disclosure by Federal Confidentiality Laws, except under the following conditions: 1) If the EAP counselor becomes aware of threats of suicide or homicide; 2) If the EAP counselor suspects a child or vulnerable person has been abused or neglected; 3) If you have an active worker's compensation claim; 4) If your records are subpoenaed for court. You may choose to sign a release of information to involve third parties, who may be able to assist in the goals of the EAP.</p> <p>Upon telephone intake, BHS offers to send you a copy of our "Notice of Privacy Practices" form which describes how your protected health information may be used and disclosed and how you can get access to this information. You may obtain additional copies by contacting BHS at 1-800-327-2251 or by downloading it from our website at www.bhsonline.com.</p> <p>I have read and understand this statement, and I have had the opportunity to receive/review a copy of BHS' Notice of Privacy Practices. Any areas of concern have been discussed with my counselor.</p>			
Client's Signature: _____			Date: _____
Counselor's Signature: _____			Date: _____