BEST CARE
EMPLOYEE ASSISTANCE PROGRAM

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Omaha, NE 68124-1900
402.354.8000 or 800.801.4182
Fax: 402.354.8046
www.BestCareEAP.org

AFFILIATE PROVIDER PACKET

Reimbursement Requirements

In order to fulfill our reporting responsibilities to our customer companies, and for you to be reimbursed for the services that you will provide for us, the following forms (Alcohol/Drug Assessment only when applicable) must be completed and returned to Best Care EAP:

Forms for affiliate counselor to complete:

Authorization of Service. This two-page form must be completed for all service billings.

Alcohol/Drug Assessment. This form is used with alcohol/drug-related referrals when an alcohol/drug assessment has been arranged. Please complete this form in its entirety, including the provision of a diagnostic impression and suggested education, counseling or treatment recommendations. **Please do not discuss final treatment recommendations with the client prior to consulting with a Best Care EAP counselor.** If counseling or treatment will likely be recommended by Best Care EAP, please include the name of a qualified provider who could provide the counseling or treatment. **Please complete the form and fax it to Best Care EAP within forty-eight hours after the assessment has been completed.**

Forms for client to complete:

Statement of Understanding. This form provides a brief overview of Best Care EAP's counseling services, including communications between Best Care EAP and you, their affiliate provider. Please have the client read and sign this form. If a client declines to sign, please note this on the form and sign and date it.

These forms can be accessed in the forms section of our web site at www.BestCareEAP.org. Feel free to duplicat the forms for use with future Best Care EAP referrals.

IMPORTANT REMINDER! In order for reimbursement to be made, Best Care EAP must have your completed *Affiliate Provider Agreement* on file.

<u>ATTENTION ALCOHOL/DRUG ASSESSMENT PROVIDER:</u> PLEASE DO NOT DISCUSS FINAL TREATMENT RECOMMENDATIONS WITH THE CLIENT PRIOR TO CONSULTING WITH A BEST CARE EAP NATIONAL COUNSELOR.

BEST CARE EMPLOYEE ASSISTANCE PROGRAM

ALCOHOL/DRUG ASSESSMENT

CLIENT NAME: _____

LAST 4 DIGITS OF CLIENT'S SS#: _____

TYPES OF ALCOHOL/DRUGS USED:

1. Type: _____
   Age of first use: _____
   Frequency: _____
   Quantity: _____
   Date of last use: _____
2. Type: _____
   Age of first use: _____
   Frequency: _____
   Quantity: _____
   Date of last use: _____
3. Type: _____
   Age of first use: _____
   Frequency: _____
   Quantity: _____
   Date of last use: _____
4. Type: _____
   Age of first use: _____
   Frequency: _____
   Quantity: _____
   Date of last use: _____

PERIOD OF HEAVIEST USE (ex.: age 20 – 22): _____

DURING PERIOD OF HEAVIEST USE:

Type of drug used: _____

Age of first use: _____

Frequency of use: _____

Quantity of use: _____

FAMILY HISTORY OF DRUG USE: _____

SYMPTOMS EXPERIENCED (IF CHECKED, PLEASE EXPLAIN):

☐ loss of control _____ ☐ black outs _____
☐ preoccupation _____ ☐ tolerance _____
☐ withdrawal _____ ☐ attempts to "cut back" _____
☐ other _____

_____

CONSEQUENCES OF USE (IF CHECKED, PLEASE EXPLAIN):

☐ marital _____ ☐ family _____
☐ physical health _____ ☐ social _____
☐ work _____ ☐ legal/DUI _____
☐ financial _____ ☐ other _____

_____

HISTORY OF TREATMENT: ☐ Yes ☐ No
If yes, where, when, type: _____

_____

12-STEP PROGRAM ATTENDANCE: ☐ Yes ☐ No
If yes, name of program and when: _____

_____

COLLATERAL SOURCE(S) CONSULTED? ☐ Yes ☐ No
If yes, please provide pertinent collateral information: _____

_____

_____

_____

TESTING TOOLS ADMINISTERED? ☐ Yes ☐ No
If yes, please list type of tool and provide interpretive summary: _____

_____

DIAGNOSIS AND/OR DIAGNOSTIC IMPRESSION: _____

_____

_____

TREATMENT RECOMMENDATIONS (TO BE REVIEWED/APPROVED BY BEST CARE EAP)

Individual Alcohol/Drug Counseling Sessions ☐ Yes ☐ No If yes, # of sessions: _____

Alcohol/Drug Treatment ☐ Yes ☐ No

☐ Level I Outpatient Days/Time/# of Sessions: _____

☐ IOP Days/Time/# of Sessions: _____

☐ Residential Days/Time/# of Sessions: _____

☐ Inpatient Days/Time/# of Sessions: _____

Education or 12-Step Program Meeting Attendance (ex: A/D Ed. and AA/NA) ☐ Yes ☐ No
If yes, education, name/location of Program: _____

If yes, AA/NA, name of Program: _____ # Meetings per week: _____

Aftercare/Continuing Care ☐ Yes ☐ No
If yes, type/frequency of aftercare/continuing care: _____ Duration: _____

If a counseling or treatment recommendation is made by Best Care EAP, can you, or your agency, provide this?
☐ Yes ☐ No

If no, please suggest an appropriate counseling or treatment provider (name, address and phone #):

_____

Please complete and fax to _____ at (402) 354-8046 within 48 hours after assessment has been completed.

NOTE: This form must be submitted along with Best Care EAP's *Statement of Understanding and two-page Authorization of Service* form in order for your services to be reimbursed.

_____ _____
Signature Date

_____ _____
Printed Name Phone Number

BEST CARE EMPLOYEE ASSISTANCE PROGRAM

STATEMENT OF UNDERSTANDING

Welcome to the Best Care Employee Assistance Program. We provide assessment, short-term counseling, and referral services to employees and eligible family members of our customer companies and organizations. These EAP services are provided at no cost to the employee or family member. It is the responsibility of the client to pay for any services outside of the EAP counseling benefit.

Services can be accessed in several ways. You may meet with a counselor in one of our Best Care EAP offices or you may meet with one of our contracted affiliate providers. You may also access our services via electronic means such as telephone, online chat or video (telehealth counseling). Telehealth counseling options are subject to the limitations of internet security, however Best Care EAP utilizes a secure, HIPAA compliant medium (WebEx) to provide those services. If you choose to use one of the telehealth options, please refer to the *Telehealth Counseling Security Statement* that will be included with this Statement of Understanding. All Best Care EAP counselors are Nebraska Licensed Mental Health Practitioners. Telehealth counseling is provided pursuant to the laws and regulations of the State of Nebraska.

All EAP counseling services are strictly confidential and your counseling information cannot be disclosed without your permission. There are a few exceptions: 1) If you see one of our affiliate providers, it is necessary for Best Care EAP and your provider to exchange counseling and billing information. 2) Certain reports to authorities are required by law, such as suicidal intent or threats of imminent physical violence toward others. 3) Suspected abuse of children, the elderly, and incompetent or disabled persons must also be reported.

In order to achieve a successful counseling outcome, you are expected to be a full participant in the counseling process. This includes arriving at mutually agreed upon counseling goals and a plan to achieve those goals with your counselor. It also includes attending sessions as scheduled. **Appointment changes with less than 24 hours notice and no shows will count as a session and be deducted from your allowed sessions.** After completing your counseling with Best Care EAP, we will solicit your feedback on that experience as an essential part of our ongoing effort to provide excellent counseling services.

It is the policy of Best Care EAP to use its best efforts to avoid participation in adversarial actions against customer companies or organizations, or in any client legal actions, such as child custody suits, divorce proceedings or personal injury lawsuits. If you are considering such actions, or are involved in such actions, your EAP counselor can refer you to an independent counseling professional for services. Since these services are outside your EAP benefits, costs for those services would be your responsibility.

If you have any questions or concerns about your EAP counseling services, please contact Best Care EAP's Clinical Services Manager, Terry Coleman, at (402) 354-8000 or (800) 801-4182. He will do his best to answer your questions or address your concerns. If you are not satisfied after speaking with Terry, please contact our Corporate Director, Jean Faber at the same number. You may also contact Jeff Prochazka, our Vice President, at Nebraska Methodist Health System, (402) 354-6078, or the Nebraska Department of Health and Human Services, Division of Public Health, Licensure Unit at (402) 471-2115, regarding your concerns.

By signing below, you acknowledge that you have read and understand this Statement of Understanding and you give your consent for Best Care EAP to provide counseling services for you and any of your minor children who participate in the counseling.

☐ **Please check this box to give Best Care EAP permission to communicate with you via email.**

Email address: _____

Date: _____ **Signature:** _____

Date: _____ **Spouse/Significant Other:** _____