



Dear Prospective Provider:

Thank you for your interest in our organization. LifeWork Strategies has been offering workplace sponsored programs to employers in our community and across the country for the past 20 years. Our mission is to promote wellness to employers in our community and nationwide by providing a full range of services aimed at helping people become more productive in their personal and professional lives. Our services include Employee Assistance & Work/Life Programs, Onsite Wellness Programs, and Medical Data Management. You may learn more about our services by visiting our website at [www.lifeworkstrategies.com](http://www.lifeworkstrategies.com).

Please take this opportunity to review the LifeWork Strategies EAP Affiliate Manual and complete our Credentialing packet. You may mail your completed paperwork to:

LifeWork Strategies, LLC  
ATTN: Provider Relations  
14915 Broschart Rd, Suite 250  
Rockville, MD 20850

You may also make prior arrangements to hand deliver your Credentialing Packet to our office so that we have an opportunity to meet in person. Once we receive and review your information a Provider Relations representative will contact you.

If you have any questions please call Lacey McCourt at 301-315-3836. Again, thank you for your interest.

Sincerely,  
Provider Relations



*Your Advocate*  
**Employee Assistance Program  
Affiliate Manual**

**LifeWork Strategies**

*Your Advocate* Employee Assistance Program

14915 Broschart Rd., Suite 250

Rockville, MD 20850

301-315-3840 or 877-777-8138 \* [www.youradvocate.com](http://www.youradvocate.com) \* [www.lifeworkstrategies.com](http://www.lifeworkstrategies.com)

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## **INTRODUCTION**

On behalf of LifeWork Strategies, LLC (LWS), we are delighted by your interest in our organization. LWS believes in encouraging individuals to take an active role in their health and well being. We seek Affiliate providers who share this approach to behavioral health and wellness.

You are an important partner in the care and services provided to EAP users and client companies. The role of an LWS Affiliate is to provide assessment, short-term problem resolution, community resources and recommendations for ongoing care as appropriate.

This Manual will assist you and your office staff in working with LWS to deliver the highest quality of services. Please take some time to familiarize yourself with the Manual, as part of your legal agreement with LWS. We look forward to working with you and encourage you to contact us if you have any questions about your role as an Affiliate or suggestions for service improvements.

## **WHAT IS AN EAP?**

“An Employee Assistance Program (EAP) “is a worksite-based program designed to assist: (1) work organizations in addressing productivity issues, and (2) “employee clients” in identifying and resolving personal concerns, including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that affect job performance.”

Source: EAPA Standards and Professional Guidelines for Employee Assistance Programs, 2003 Edition

### The Value of EAP

- Improve Quality of Life & Well being
- Enhance Productivity
- Reduced Absenteeism
- Reduced Use of Sick Leave
- Reduced Accidents
- Improved Retention

## **WELCOME TO LIFEWORk STRATEGIES**

Based in Rockville, Maryland, LWS offers EAP, Work/Life, Behavioral Health and Workplace Wellness services to employers in our community and across the country. LWS is an Affiliate of Adventist HealthCare, a non-profit network of health care providers that includes hospitals, home health agencies, nursing centers and other health and wellness services throughout the mid-Atlantic region.

*Your Advocate* is the Employee Assistance Program offered by LWS. The *Your Advocate* Program is rooted in the core principles of EAP - professional, confidential counseling and referral services sponsored by the workplace - yet we offer a range of ancillary services to enhance support to individuals and their families and to meet our customers' changing needs.

We strive to deliver confidential, quality services to help Clients successfully meet home and workplace challenges. Affiliates are encouraged to be familiar with the continuum of benefits to be able to refer Clients back to LWS for additional support that may include:

### **CLINICAL SERVICES**

1. Toll-free telephone help-line access 24 hours a day, 7 days a week
2. Intake assessment of situation by Masters level counselors and direct referral to network EAP Affiliates
3. Face-to-face individual assessment, short-term counseling
4. Referral to appropriate community resources as needed
5. Follow up to ensure satisfaction with assistance received
6. HR & Management consultation regarding "troubled employees" to assist supervisors in the process of making referrals to the EAP
7. Crisis Intervention: Consultation, Planning, and Debriefing
8. Substance Abuse Professional (SAP) Services

### **WORK/LIFE SERVICES**

#### ***Child Care & Parenting***

- Expecting Parent Toolkit
- Adoption resources and referrals
- Child care consultation and referrals
- Nanny care information and resources
- Pre-school and private schools searches
- Special Needs Care resources (e.g. ADHD)
- College planning resources packet
- Parent Coaching on development & communication issues

#### ***Elder Care***

- Senior care consultation and referrals
- Geriatric Care Management referrals
- Special Needs Care resources (e.g. Alzheimer's)

#### ***Legal Consultation***

- Unlimited phone consult with an attorney
- Attorney referral, offering free half-hour face-to-face consultation & 25% discount on services

#### ***Financial Consultation***

- Unlimited phone consult with financial educator
- Unbiased, educational, strategic support

#### ***Wellness Coaching***

- One 45 min phone consult, per issue, per year, with a Wellness Coach, e.g., RD or Exercise Physiologist to identify a goal and develop a plan
- Check in call two weeks later and over the course of 2 months for support and accountability and referral to local resources

## **THE AFFILIATE'S ROLE**

Your role is to provide assessment, short-term counseling (as appropriate), referral and follow-up. Please pay attention to available insurance benefits when making referrals.

It is important that you maintain a neutral position in regard to potential adversarial situations such as grievances, disability claims, harassment, wrongful termination, etc. If you are contacted by an attorney regarding a client you are seeing or have seen for LWS, please contact us prior to providing any information. If accusations of any type of harassment are made, please notify LWS.

You are a valued member of the LWS team. When you are providing EAP Services to a Client or Employer and/or are making a referral, we appreciate your representation of LWS. With your assistance, our Clients receive the best possible quality service.

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

## **CLIENT ACCESS PROCESS**

- The Client calls 1-877-252-8550 and is greeted by a Masters level Counselor (EAP Specialist).
- The EAP Specialist (*your designated contact at LWS*) conducts a clinical intake and determines the Client's needs.
- If a referral to an Affiliate is deemed appropriate, the EAP Specialist will provide the Client with the contact information of an Affiliate whose specializations and office location are applicable to the Client's needs.
- The EAP Specialist will fax you the Client referral which includes:
  - Client's name, address, and phone numbers
  - The presenting problem
  - The number of sessions available
- The Client should contact you within one week of this referral. Once the Client has contacted you, a call should be returned within 24 hrs and an appointment should be offered within 72 hrs of the conversation. After scheduling the appointment, please notify LWS of appointment date and time by leaving a message on the administrative line (301-315-3840) or by emailing or calling *your designated contact at LWS*.
- If you do not hear from the Client, you should make a follow-up call to the Client. If the Client does not respond within two weeks of the date in which the client was referred, please notify *your designated contact at LWS* and the case will be closed. If the Client contacts you after the two week period, the Client should be directed back to LWS at 1-877-252-8550.

- If a Client calls your organization and you have no knowledge of the referral, you may go ahead and schedule an appointment for the Client. However, the Client or someone from your organization must call LWS for authorization of session(s) as soon as possible, or payment of services will be denied.
- During the first session, have the Client sign the Statement of Understanding (see attached) and complete the Personal History Form (see attached).
- **You may use up to three visits to assess the Client. Following assessment of the issue, call *your designated contact at LWS* to review the case; together it will be determined if the client should be referred out or complete any available EAP sessions.** If the Client wishes to be referred to you for continuing treatment as determined clinically necessary, the Affiliate and Client must complete a Self Referral Form. The form should be requested before closing the EAP case.
- If a Client was seen and more than two weeks pass with a break in communication (i.e. follow up appointment not kept; follow up calls not returned), the case may be closed and paperwork should be submitted. Otherwise, you may call LWS to report break in service. Together, we will determine if the case should remain open.
- Any family member seen will need a Client referral number provided by LWS and must sign a SOU. If a family member attends the Client's session, this is considered a family case, needing only one Case Closing Form and one Invoice. If at any time a family member is seen individually, that person becomes a separate case and will require a separate Case Closing Form and Invoice. The Affiliate is paid per session, not per person.
- After the case has been closed, submit all completed paperwork including the SOU, Personal History Form, Case Closing and Invoice in order for LWS to process payment. Per the Participating Provider Agreement, paperwork should be submitted for payment within fourteen (14) days of last day of the month in which the services were completed. **Any required documentation and related materials submitted after sixty (60) days of the last day of the month in which provider completed services will not be reimbursed.**

## ASSESSMENT

The EAP Specialist determines the Client's *presenting problem* and the Affiliate identifies the *assessed problem*.

The Affiliate must utilize problem identification and/or assessments to identify and evaluate the Client's strengths, weaknesses, problems and needs in order to develop an appropriate action plan. Basic elements of an assessment include:

- a. Client statement of presenting problem & desired outcome
- b. Level of risk to self and others
- c. Any precipitating event
- d. Impact on current job performance
- e. History of presenting issue
- f. Coping strategies
- g. Relevant work history / Education / Military background

- h. Mental health history & current status
- i. Alcohol & drug use/abuse history & current
- j. Medical history & current
- k. Relevant family history
- l. Support System
- m. Strengths & challenges
- n. Initial impression

## **SHORT-TERM SOLUTION FOCUSED SERVICES**

EAP sessions are used for Short-Term Solution Focused services. The sessions should build on existing strengths, promote independence, take into consideration the cultural values held by the Client, and encourage use of community resources such as AA and other self-help groups.

- The purpose of Short-Term Solution Focused services 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 Solution Focused services is to provide clarification, education, support and motivation to the Client. Short-Term Solution Focused services differ from therapy in that it is a brief, problem-resolution service, which may be an effective way for a Client to resolve a concern.
- This service allows the Client to receive needed assistance without having to access their health benefits, and incur costs when the problem appears to be short-term and can potentially be resolved within the identified number of sessions.

### **Short-Term Solution Focused**

- 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 Counseling versus other services, demonstrates the ability to understand the scope and limitations of Short-Term Counseling and agrees to receive Short-Term Counseling.

## LONG-TERM INTERVENTION

If your assessment indicates a need for mental health treatment rather than Short-Term Solution Focused services, Affiliates should explain their rationale to the Client, and refer the Client directly to a provider covered by the Client's health plan. Affiliates can self-refer when appropriate. 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.

### **Long-Term Intervention**

- The Client's presenting issue is a complex/multi-problem.
- The Client is not readily motivated for treatment.
- The Client may have had prior ineffective treatment experiences.
- Focused problem needing treatment is not amenable to short-term intervention.

## REFERRAL GUIDELINES

You are responsible for finding appropriate, quality services for Clients who need referrals beyond the program. You are also responsible for assisting clients with insurance benefit questions.

For outpatient referrals, you should consider the Client's clinical needs, geography, financial resources and personal preferences. It is your responsibility to refer Clients to resources covered by insurance and on the company's Preferred Provider Organization when available and appropriate. You may call LWS for assistance.

LWS has some insurance information on file for our customers. However, many companies offer several plans and make changes frequently that we strongly recommend that Affiliates confirm benefits directly with your Client. Also, encourage the Client to confirm their eligibility and coverage with the insurance carrier again just before their first visit.

In some cases the EAP is the gatekeeper for mental health benefits. For Clients whose insurance requires a gatekeeper, please consult with LWS for information regarding how to proceed.

Keep in mind additional resources such as:

- Community resources such as AA and other self-help groups
- Workplace Resources
- Additional EAP services

## MANAGEMENT REFERRALS

**Note: Only those Affiliates who have indicated an interest in receiving Management Referrals and have demonstrated their knowledge of EAP procedures will be given such cases.**

The majority of Clients you will see for LWS will be self-referred. Occasionally, company management will become involved in a case by mandating that an employee call the EAP.

A management or mandatory referral occurs when the Supervisor requires that an employee access the EAP or risk losing their job due to poor job performance or other concerns.

When LWS refers one of these cases to you, you will be given specific instructions on how to handle the case.

On the following page you will find the supervisory Referral Guidelines. Feel free to use this as an additional resource.

## **MANAGEMENT REFERRAL PROCEDURE AND GUIDELINES**

- You will receive the Client referral from *your designated contact at LWS* via fax with the following information:
  - Client's name and phone number.
  - Reason for referral.
  - Number of sessions available.
  - A copy of the EAP Referral Agreement signed by the Client (employee) and the referring Supervisor/Manager.
  - Statement of Understanding Form (SOU)
  - Release of Information Form (ROI)
- Prior to meeting with the Client, LWS will contact you for discussion of the case.
- The Client should contact you within 24 hrs and an appointment should be scheduled within 24 business hrs of their call. After scheduling the appointment, please call *your designated contact at LWS* to notify of the appointment date and time.
- The Client must sign a SOU and ROI during the first appointment.
- After each session, contact *your designated contact at LWS* to discuss your assessment and recommendations. You may use additional sessions for the assessment if necessary. Based on your recommendations, *your designated contact at LWS* will create an agreement letter which you will present to the Client at the next session and have them sign. **Please do not discuss your recommendation(s) with the Client prior to speaking to *your designated contact at LWS*.**
- During the next session, discuss the recommendations with the Client. Have the Client sign the agreement letter. Advise the Client that the agreement can be revised if necessary. Fax or send a copy of the signed agreement to LWS. **Please note that LWS will communicate with the company regarding the employee's progress.**
- If a referral to additional treatment is given (i.e. Psychiatrist), please follow-up with the treatment provider and the Client for progress reports. Notify LWS with this information immediately.
- If a Client is non-compliant with treatment recommendations and/or fails to attend scheduled appointments, notify the LWS immediately.
- Contact LWS with any questions or concerns.

## EAP DO'S & DON'TS

Serving our EAP Clients means knowing some “basics” about how the EAP process operates. The following are guidelines on how we can work together to increase Client and account satisfaction.

- **Do** contact LWS with questions regarding client referrals, authorizations, billing procedures or additional sessions.
- **Do** respond to referral phone calls within 24 hours, even if you cannot accept a referral. It is our policy to have Clients in contact with an Affiliate within 24 hours to schedule an appointment.
- **Do** contact LWS immediately with issues concerning your Client’s workplace, such as safety, hostile work environment, sexual harassment, leaves of absence, disability forms/questions, and legal documents.
- **Do** contact LWS if the Client is in a court referred program.
- **Do** refer clients back to LWS for additional resources such as legal and financial consultations and eldercare/childcare resources and referrals.
- **Don’t** fill out forms for Clients without first contacting LWS to discuss their request, such as requests for personal leave, short term disability forms, and family medical leave forms.
- **Don’t** contact the Client’s Employer or related Organization (e.g. union). LWS will handle these types of communications or authorize you to do so, on a case-by-case basis.
- **Don’t** send letters requested by a Client to the Employer without first talking with LWS.
- **Don’t** make any remarks that could be interpreted as negative comments about an Employer. If you have concerns about a workplace environment, call and discuss with LWS. Don’t initiate contact with an employer.

Thank you for taking the time to familiarize yourself with our Affiliate Manual. We look forward to working with you.

# Affiliate Credentialing Paperwork to Return

Please mail back the following:

- Signed Contract
- Copy of License, Malpractice Liability, & Resume
- Completed Affiliate Information Form
- 3 Professional References
- Completed & Signed W-9

Mail To:

ATTN: Provider Relations  
LifeWork Strategies, LLC  
14915 Broschart Rd, Suite 250  
Rockville, MD 20850

***LifeWork Strategies, LLC***  
**Provider Agreement for EAP Counselors**

THIS AGREEMENT, made this \_\_\_\_ day of \_\_\_\_\_, between and among LifeWork Strategies, LLC 14915 Broschart Road, Suite 250, Rockville, Maryland, (referred herein as “Contractor”), and \_\_\_\_\_ (“Provider”). Contractors and Provider may hereafter be referred to individually as a “Party” and collectively as the “Parties.”

WHEREAS, Contractors are engaged in arranging for the provision of employee assistance programs (“Programs”) to employers, unions, employee benefit funds, insurance companies, governmental organizations, and various other purchasers of health services, for the benefit of their respective employees or covered persons (“Covered Persons”); and

WHEREAS, Contractors wish to retain the services of Provider to provide clinical evaluation, treatment and other related health care service to such Covered Persons, and Provider wishes to provide such services;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, and intending to be legally bound hereby, it is understood and agreed by the Parties as follows:

**I. DEFINITIONS**

- A. “Covered Person” shall mean any employee of the Employer and if so designated by Employer, his/her dependents.
- B. “Provider” shall mean a provider designated by Contractors to provide employee assistance services.
- C. “Covered Services” shall mean all related employee assistance services rendered to a Covered Person by a Provider to the extent that such services are for the treatment of personal and psychological problems.
- D. “Dependents” shall mean any individual residing within the household of the Covered Person, including, but not limited to, significant others and life partners. Also included shall be dependent children living outside the household to age 25 for full-time students.
- E. “Occurrence” shall mean the presentation of a specific set of problem issues.
- F. “Employer” shall mean any business, union, employee benefit fund, insurance company or governmental agency having an agreement with Contractors to provide employee assistance programs.

**II. PROVIDER RESPONSIBILITIES**

The Provider shall:

- A. Warrant and represent that he/she is the holder of a duly-authorized and valid professional license for independent practice of his/her profession.
- B. Provide evidence of such license and certificate of insurance to Contractors with this signed contract and regularly thereafter upon renewal of such license and insurance.

C. Provide services consistent with Provider's training, experience, specialization, if any, and the ethics of Provider's profession.

D. Accept Covered Members referred on an "as needed" basis by the Programs to provide clinical evaluation/assessment, counseling, treatment, referral, and other related services, as approved or directed by the Programs.

E. In the course of typical business:

1. Respond to telephone calls, either from contractor or covered person, within 24 hours.
2. For non-urgent referrals, offer appointments within seventy-two hours of covered person's call to provider.
3. For urgent referrals, offer appointments that are within forty-eight hours of covered person or contractors call to provider.

F. Provide Covered Persons the number of hourly sessions which will be determined by the Programs' contract, subject to limitations communicated by the contractor. Upon completion of assessment, provider will consult with the contractor's clinical department, unless otherwise notified.

G. Not be reimbursed for no-shows or cancellations. Provider may enforce his/her own policy so long as the policy is communicated to the covered person in advance.

H. Review with and ask the Covered Person to sign the Statement of Understanding, and Release of Information Form, (if applicable) at the beginning of the initial session and complete the Case Closing Form after the last contact with the Covered Person, if required by Contractor.

I. Maintain a written record of initial assessment and all clinical contacts with Covered Persons for a minimum of five years from date of last contact with Covered Person. Such information shall include, but not be limited to: client presenting concerns, pertinent family, social, occupational, health and substance use/abuse history, mental status, clinical diagnosis and recommendations for appropriate intervention.

J. Cooperate with and provide Contractors and any external quality review organization approved by the Contractors with access to or mailed photocopies of Covered Persons' records upon request for the purposes of quality assessment, contract compliance, and quality improvement or investigation of member complaints or grievances. Provider further agrees to provide such information, including but not limited to encounter, utilization, referral and other data Contractors may require to be submitted to them for compliance with their own data reporting requirements.

K. Utilize the appropriate insurance network for referrals for ongoing treatment and clearly document the referral source name, address and telephone number.

L. Return to the Programs all original paperwork, including the Case Closing Form, Statement of Understanding, and any necessary Release of Information Forms within fourteen (14) days of the last session with the Covered Person in order to receive reimbursement, if required by Contractor. This responsibility also extends to required paperwork associated with CISD's and trainings.

M. Understand and agree that all Covered Persons referred to the Provider by the Programs, directly or indirectly, shall remain at all times the sole and exclusive clients of the Programs.

N. Provider agrees to comply with and be bound by all rules, regulations, policies, and programs of the Programs that may have been or may hereinafter be adopted.

### **III. CONTRACTOR'S RESPONSIBILITIES**

A. If applicable, reimburse Provider within forty-five (45) days of receipt of the Case Closing Form, Statement of Understanding, and if indicated, Release of Information Forms, in the form required by the Programs if these reports are required. Contractor will compensate Provider for CISD's and trainings upon receipt of payment from Employer within forty-five (45) days of receipt of funds.

B. Notify the Provider of any significant changes in the Employee Assistance Program Agreement with Employers and Contractors that would impact this Agreement.

C. Maintain adequate insurance for professional liability and comprehensive general liability to insure the Programs and their employees against liability for all claims, demands, costs, or damages that may arise in connection with the performance of any service or activity performed by the Programs in connection with this Agreement.

### **IV. COMPENSATION AND PAYMENT**

A. Provider shall be paid on a fee-for-service basis, or other basis as mutually agreed, at the rate indicated on Exhibit A, as full compensation for Provider's services to Covered Persons.

B. Provider shall submit required documentation and related materials to the Contractor for payment, in the form required by the Contractor, within fourteen (14) days of last day of the month in which Provider's services were completed. Any required documentation and related materials submitted after sixty (60) days of the last day of the month in which Provider completed services will not be reimbursed to Provider.

C. Provider agrees that in no event, including but not limited to, nonpayment by the Contractors, the insolvency of the Contractors, or breach of this agreement, shall Provider bill, charge or collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or Persons other than the Contractors acting on their behalf for services listed in this agreement.

### **V. TERM AND TERMINATION**

A. This Agreement shall be in effect for a term of one (1) year from \_\_\_\_\_ to \_\_\_\_\_ and shall be renewed automatically at the end of this period for successive one (1) year terms from the Anniversary Date, unless otherwise terminated by either Party with sixty (60) days prior written notice to the end of each contract period.

B. This Agreement may be terminated at any time, without cause, upon ninety (90) days prior written notice to the other Party.

C. This Agreement may be terminated upon breach by one Party provided that (i) the non-breaching Party has provided written notice of such breach and the (ii) breaching Party has not cured the breach to the non-breaching Party's satisfaction within thirty (30) days.

D. Contractors shall have the right to terminate this Agreement immediately and without notice on such date as Provider's license and/or insurance, as specified in Section VI. Below, is terminated, suspended or not renewed.

E. Following the effective date of termination, each Party shall remain liable for any obligations or liabilities arising from activities carried on prior to the effective date of termination.

## **VI. INSURANCE**

A. Provider will possess and maintain, at Provider's own expense, professional liability insurance covering the Provider against claims arising out of the performance of Provider's services hereunder, in an amount not less than One Million Dollars (\$1,000,000.00) per occurrence, and Three Million Dollars (\$3,000,000.00) in the annual aggregate. If the insurance is maintained on a "claims-made" basis, Provider shall obtain and maintain "tail" coverage or "prior acts" coverage to cover claims made after the termination of such insurance or of this Agreement for any occurrence prior to such termination. Provider shall, upon execution of this Agreement and at other times as Contractors may request, provide Contractors with a certificate of insurance evidencing the required coverage. Provider shall notify, or cause its insurance to notify, Contractors at least ten (10) days prior to any reduction, modification or cancellation of the required coverage.

B. Provider warrants that if, at any future time, Provider's professional liability insurance is terminated, suspended or not renewed, Provider will notify Contractors in writing within seventy-two (72) hours of receiving such notification.

## **VII. INDEMNIFICATION**

A. Provider shall defend, indemnify and hold harmless Contractors, their governing board members, officers, employees, agents and affiliates against and from any and all liability, claims, demands, suits, administrative claims, actions, settlements, judgments, damages, costs or fee (including reasonable attorneys' fees), which Contractors, their governing board members, officers, employees, agents or affiliates may suffer or be required to pay, in law or in equity, whether or not formal legal action is commenced, resulting directly or indirectly from the actions or omissions of Provider or its officers, directors, agents or employees in the provision of services or performance under this Agreement.

B. Contractors shall defend, indemnify and hold harmless Provider, its governing board members, officers, employees, agents and affiliates against and from any and all liability, claims, demands, suits, administrative claims, actions, settlements, judgments, damages, costs or fees (including reasonable attorneys' fees), which Provider, its governing board members, officers, employees, agents or affiliates may suffer or be required to pay, in law or in equity, whether or not formal legal action is commenced, resulting directly or indirectly from the actions or omissions of Contractors or their officers, directors, agents or employees in the provision of services or performance under this Agreement.

## **VIII. CONFIDENTIAL/PROPRIETARY INFORMATION**

A. All patient records and information concerning the services provided to Covered Persons shall be kept confidential from all parties other than the Programs, as required by law. All such patient records shall constitute the property of the Programs.

B. All information and materials provided by the Programs to Provider constitute confidential information and shall remain proprietary to the Programs, including but not limited to contracts, fee schedules, procedures and operations manuals. Provider shall not use or disclose any such information or materials during or subsequent to Provider's affiliation with the Programs, except as required to carry out Provider's obligations hereunder.

C. Provider agrees that confidential information that may be disclosed by the Programs identifying eligible Covered Persons by name, social security number or other personal information, including applicable

benefits coverage, may only be used by the Provider for the purpose of providing the services outlined in this Agreement.

D. Provider agrees not to solicit Contractor's employer or other contracts/relationships during the term of this contract and for one year after the termination of this contract. Provider recognizes Contractor has expended considerable energy and monies to enroll Provider within Contractor network. This provision may be nullified upon written consent by both parties.

## **IX. MISCELLANEOUS**

A. **Independent Contractor.** It is expressly acknowledged hereto that Provider is an independent contractor and nothing in this Agreement is intended nor shall be construed to create any relationship between Provider and Contractors other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement or to allow Contractors to exercise control or direction over the method or the manner of Provider's performance of this Agreement.

B. **Use of Name.** During the term of this Agreement and any renewal thereof, Contractors may include Provider's name, address, telephone number and nature and scope of services to be included in any membership roster that may be prepared for distribution by the Programs.

C. **Amendment.** This Agreement may not be amended or revised except with the prior written consent of all Parties.

D. **Assignment.** No assignment, subcontracting or delegation of the rights, duties or obligations of this Agreement shall be made by Provider without the express written approval of the duly authorized representatives of the Programs.

E. **Severability.** Should any part of this Agreement be declared invalid, for any reason, the remainder shall continue in force and be interpreted as if the invalid portion were omitted.

F. **Force Majeure.** No Party shall be deemed to have breached this Agreement for delay caused by occurrences beyond the reasonable control of that party, including, but not limited to, acts of God, acts of any government, wars, rebellion and sabotage, strikes, or severe weather, and any time for performance shall be extended by the actual time of delay caused by such occurrence.

G. **Governing Law.** This Agreement shall be construed in accordance with the laws of the State of Maryland.

H. **Entire Agreement.** This Agreement is the entire agreement between Contractors and Provider concerning the subject matters herein and supersedes any previous such agreements Provider may have entered with Contractors and/or the Programs. No other agreements or modifications to this Agreement, whether oral or written, shall be effective unless they are incorporated into this Agreement or a supplement hereto signed by all the Parties.

I. **Waivers.** No waiver of any term, provision or condition of this Agreement, whether by conduct or otherwise, in any one or more instances, shall be deemed or construed as a further or continuing waiver of any such term, provision or condition of this Agreement.

J. **Gender.** All terms as used in this Agreement, regardless of the number and gender in which they are used, shall be deemed to include singular and plural, masculine, feminine, or neuter, as the context or sense of this Agreement may require.

K. **Nondiscrimination.** The Parties agree that they shall perform their respective obligations hereunder without discrimination toward any Covered Person, employee or other persons regardless of their race, age, creed, color, gender, disability or ethnic background.

L. **Notices.** Notices required hereunder shall be provided by first class mail, as follows:

If to Provider: \_\_\_\_\_  
\_\_\_\_\_

If to Programs: \_\_\_\_\_  
LifeWork Strategies, LLC  
14915 Broschart Road, Suite 250  
Rockville, MD 20850

IN WITNESS WHEREOF, the parties have executed this Agreement on the date and year first above written.

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Provider)

By: \_\_\_\_\_

Title: \_\_\_\_\_

Tax ID#: \_\_\_\_\_

\_\_\_\_\_  
(Witness)

***LifeWork Strategies, LLC***

By: \_\_\_\_\_

Title: \_\_\_\_\_

**HIPAA BUSINESS ASSOCIATE ADDENDUM (COVERED ENTITY FRIENDLY) THIS**

**ADDENDUM** (“Addendum”) is entered into as of the Effective Date (defined below), between Covered Entity and Vendor.

**RECITALS:**

**COVERED ENTITY:**

\_\_\_\_\_  
 (“Provider”).

**VENDOR:**

LifeWork Strategies, LLC (“Vendor”).

**ADDENDUM EFFECTIVE DATE:**  
 (“Effective Date”).

**ORIGINAL SERVICES AGREEMENT:**

\_\_\_\_\_  
 (“Services Agreement”)

**SIGNATURES**

(By signing below the parties agree to the terms of this Addendum)

**PROVIDER (Covered Entity)**

By:  
Print Name:  
Title:  
Address:  
Facsimile Number:

**VENDOR (LWS)**

By:  
Print Name: Kacy Rollins, LCSW-C, CEAP  
Title: Manager of EAP Services  
Address: 14915 Broschart, RD Suite 250, Rockville,  
MD 20850  
Facsimile Number: 301-315-3838

**A.** Pursuant to that certain Services Agreement between Covered Entity and Vendor, Vendor provides services to Covered Entity and, in connection therewith, Vendor requires access to certain individually identifiable health information maintained by Covered Entity; and

**B.** Pursuant to the Health Insurance Portability and Accountability Act of 1996, Subtitle F, Public Law 104-191, Section 261, et seq., and the final rules promulgated thereunder from time to time by the United States Department of Health and Human Services (collectively, the “HIPAA Standards”), Covered Entity must obtain the satisfactory assurances contained herein from Vendor before Covered Entity discloses to Vendor, or permits Vendor to create or receive on behalf of Covered Entity, individually identifiable health information relating to Covered Entity’s patients. For purposes of this Addendum, the term “PHI” shall mean any such “protected health information” (as defined under the HIPAA Standards) disclosed by Covered Entity to Vendor or created or received by Vendor on behalf of Covered Entity.

**NOW THEREFORE**, the parties agree as follows:

**1. Use and Disclosure of PHI.** Vendor agrees that it will not use or further disclose PHI other than as permitted or required under this Addendum or as otherwise required by law. In connection with the foregoing, Vendor agrees that it will not use or disclose PHI except:

- (a) Subject to Section 4 hereof, Vendor may use or disclose PHI for the purpose of performing its services under the Services Agreement;
- (b) Vendor may use PHI for its proper management and administration or to carry out its legal responsibilities; and
- (c) Vendor may disclose PHI for its proper management and administration or to carry out its legal responsibilities if such disclosure is required by law; and

(d) Vendor may disclose PHI for its proper management and administration or to carry out its legal responsibilities if (i) Vendor obtains reasonable assurances from the person to whom such PHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and (ii) such person agrees to notify Vendor of any instance of which it is aware in which the confidentiality of such PHI has been breached.

**2. Safeguards Against Misuse of Information.** Vendor agrees that it will use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for in this Addendum.

**3. Reporting of Disclosures of PHI.** Vendor shall, within five (5) days of becoming aware of any use or disclosure of PHI other than as provided in this Addendum by Vendor, its officers, directors, employees, contractors or agents or by a third party to which Vendor has disclosed PHI, report any such disclosure to Covered Entity.

**4. Agreements by Third Parties.** Vendor shall enter into an agreement with any agent or subcontractor of Vendor that will have access to PHI pursuant to which such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to Vendor pursuant to this Addendum with respect to such information.

**5. Access to Information.** Within five (5) days of a request by Covered Entity for access to PHI about an individual, Vendor shall make available to Covered Entity such PHI. In the event any individual requests access to PHI directly from Vendor, Vendor shall within two (2) days forward such request to Covered Entity. Any denials of access to PHI requested shall be the responsibility of Covered Entity.

**6. Availability of PHI for Amendment.** Within five (5) days of receipt of a request from Covered Entity for the amendment of an individual's PHI, Vendor shall provide such information to Covered Entity for amendment and incorporate any such amendments to PHI in accordance with 45 C.F.R. §164.526.

**7. Accounting of Disclosures.** Within five (5) days of notice by Covered Entity to Vendor that it has received a request for an accounting of disclosures of PHI regarding an individual during the six (6) years prior to the date on which the accounting was requested, Vendor shall make available to Covered Entity such information as is in Vendor's possession and is required for Covered Entity to make an accounting in accordance with 45 C.F.R. §164.528. At a minimum, Vendor shall provide Covered Entity with the following information: (a) the date of the disclosure, (b) the name of the entity or person who

received PHI, and if known, the address of such entity or person, (c) a brief description of PHI disclosed, and (d) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure. In the event the request for an accounting is delivered directly to Vendor, Vendor shall within two (2) days forward such request to Covered Entity. It shall be Covered Entity's responsibility to prepare and deliver any such accounting requested. Vendor hereby agrees to implement an appropriate recordkeeping process to enable it to comply with the requirements of this Section.

**8. Availability of Books and Records.** Vendor hereby agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Vendor on behalf of, Covered Entity available to the Secretary of the United States Department of Health and Human Services for purposes of determining Covered Entity's compliance with the HIPAA Standards.

**9. Additional Amendments.** Vendor agrees it will, from time to time, enter into any additional amendments hereto to permit Covered Entity to comply with the HIPAA Standards.

**10. Termination.** Without limiting Covered Entity's other termination rights under the Services Agreement, in the event of that Covered Entity determines that Vendor has violated a material term of this Addendum, Covered Entity may terminate the Services Agreement by giving of a written notice of termination to Vendor. Upon termination of the Services Agreement for any reason, Vendor agrees that it will return all PHI (without retaining any copies thereof) received from, or created or received by Vendor on behalf of, Covered Entity; provided, however, if returning such PHI is not feasible, Vendor will destroy all such information. In the event that the return or destruction of such information is not feasible, Vendor agrees that it will extend the protections of this Addendum to such information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

# LIFEWORK STRATEGIES

14915 Broschart Rd., Suite 250, Rockville, Maryland 20850

## Affiliate Information Form

### Demographic Information

LAST FIRST MI CREDENTIALS

ORGANIZATION NAME/ PRIVATE PRACTICE

DOB: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_  FEMALE  MALE

TIN # NPI #

MAILING/BILLING ADDRESS

CITY STATE ZIP

OFFICE ADDRESS

CITY STATE ZIP

OFFICE ADDRESS (2<sup>nd</sup> location)

CITY STATE ZIP

OFFICE/S HANDICAPPED ACCESSIBLE:  Y  N ACCESSIBLE BY PUBLIC TRANSPORTATION:  Y  N

WORK # CELL # FAX #

E-MAIL ADDRESS WEBSITE URL

PREFERRED METHOD OF RECEIVING REFERRALS:  FAX  E-MAIL

## Areas of Expertise

Please check all that apply:

### Specializations

- |   |  |
|---|--|
| <input type="checkbox"/> ACOA                         | <input type="checkbox"/> Infertility/Reproductive Issues |
| <input type="checkbox"/> ADHD/ADD                     | <input type="checkbox"/> Interpersonal Relationships     |
| <input type="checkbox"/> Adolescent                   | <input type="checkbox"/> Learning Disabilities           |
| <input type="checkbox"/> Adjustment Disorders         | <input type="checkbox"/> Legal Problems                  |
| <input type="checkbox"/> Adult                        | <input type="checkbox"/> Life Coaching                   |
| <input type="checkbox"/> Anger Management             | <input type="checkbox"/> Life Transitions                |
| <input type="checkbox"/> Anxiety Disorders            | <input type="checkbox"/> Marital/Couples                 |
| <input type="checkbox"/> Autism/Asperger's            | <input type="checkbox"/> Meditation                      |
| <input type="checkbox"/> Behavior Problems            | <input type="checkbox"/> Men's Issues                    |
| <input type="checkbox"/> Biofeedback                  | <input type="checkbox"/> Mood Disorders                  |
| <input type="checkbox"/> Career                       | <input type="checkbox"/> OCD                             |
| <input type="checkbox"/> Child                        | <input type="checkbox"/> ODD                             |
| <input type="checkbox"/> Child Abuse/Trauma           | <input type="checkbox"/> Parenting                       |
| <input type="checkbox"/> Child Custody                | <input type="checkbox"/> Personality Disorders           |
| <input type="checkbox"/> Christian/Spiritual          | <input type="checkbox"/> Psychological Testing           |
| <input type="checkbox"/> CISD                         | <input type="checkbox"/> Psychotic Disorders             |
| <input type="checkbox"/> Cognitive Disorders          | <input type="checkbox"/> Relationships                   |
| <input type="checkbox"/> Compassion Fatigue           | <input type="checkbox"/> SAP/DOT Evaluations             |
| <input type="checkbox"/> Conduct Disorder             | <input type="checkbox"/> School/Education                |
| <input type="checkbox"/> Chronic Pain                 | <input type="checkbox"/> Sexual Addiction                |
| <input type="checkbox"/> Cult Issues                  | <input type="checkbox"/> Sexual Disorders                |
| <input type="checkbox"/> Cultural/Ethnicity           | <input type="checkbox"/> Sexual Trauma                   |
| <input type="checkbox"/> Desensitization              | <input type="checkbox"/> Sleep Disturbances              |
| <input type="checkbox"/> Developmental Disorders      | <input type="checkbox"/> Stress Management               |
| <input type="checkbox"/> Dissociative Disorders       | <input type="checkbox"/> Substance Abuse                 |
| <input type="checkbox"/> Divorce/Separation           | <input type="checkbox"/> Women's Issues                  |
| <input type="checkbox"/> Domestic Violence            | <input type="checkbox"/> Work Issues                     |
| <input type="checkbox"/> EAP Counseling               | <input type="checkbox"/> Trauma/PTSD                     |
| <input type="checkbox"/> Eating Disorders             |  |
| <input type="checkbox"/> Family                       |  |
| <input type="checkbox"/> Financial/Budget             | <b>Orientation</b>                                       |
| <input type="checkbox"/> Fitness for Duty Evaluations | <input type="checkbox"/> CBT                             |
| <input type="checkbox"/> Gambling Addiction           | <input type="checkbox"/> Coaching                        |
| <input type="checkbox"/> Gay/Lesbian Issues           | <input type="checkbox"/> Eclectic                        |
| <input type="checkbox"/> Gender Identity Issues       | <input type="checkbox"/> Gestalt                         |
| <input type="checkbox"/> Geriatrics (65 + yrs)        | <input type="checkbox"/> Humanistic                      |
| <input type="checkbox"/> Groups                       | <input type="checkbox"/> Psychoanalytic                  |
| <input type="checkbox"/> Grief/Loss                   | <input type="checkbox"/> Psychodynamic                   |
| <input type="checkbox"/> Hypnosis                     | <input type="checkbox"/> Transpersonal                   |
| <input type="checkbox"/> Imago Therapy                | <input type="checkbox"/> EMDR                            |
| <input type="checkbox"/> Impulse Control Disorders    | <input type="checkbox"/> REBT                            |
|   | <input type="checkbox"/> Solution Focused                |

Please indicate if you have interest in Management Referrals Yes No

1. Please highlight those areas in which you have advanced training and expertise:

---

---

---

2. Highest Degree: \_\_\_\_\_ Year Degree Awarded: \_\_\_\_\_

3. Current certifications (Including the CEAP) and or Licenses. Please list state in which you hold certification and/or license:

---

4. Please list training, expertise, and/or experience in Critical Incident Stress Debriefings:

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---

5. Please list prior experience working with EAP's:

---

---

6. Current Membership in Professional Associations:

---

7. Please list the Insurance Panels for which you are an in-network provider:

---

8. What resources or methods do you utilize to research community referrals and/or resources for your clients? On average, how often would you say you make such referrals?

---

---

9. Please list languages you speak fluently:

---

10. Do you have experience presenting workshops/seminars in a worksite environment?  Y  N

11. If yes, would you be interested in providing this type of service to our client companies?  Y  N

12. If yes, please select the topics in which you can present:

### Areas of Expertise

- Legal
- Parenting
- Eldercare
- Nutrition
- Cardiac
- Organizational Development
- Finance
- Cancer Prevention
- Health and Medicine
- Health Screenings
- Spiritual
- Mental Health
- Fitness
- Professional Development
- Wellness/Life Coaching
- Smoking Cessation

OTHER:

### Availability

Please circle the days and times in which you are available to provide services:

Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning	Morning	Morning	Morning	Morning	Morning	Morning
Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon	Afternoon
Evening	Evening	Evening	Evening	Evening	Evening	Evening

Are you willing to travel in and around the MD, DC, and VA area? Please be specific.

---

---

I certify that the information and attachments I have provided to LifeWork Strategies is true and accurate to the best of my knowledge.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**PROFESSIONAL REFERENCES FOR PROVIDER**

Evaluation for: \_\_\_\_\_

<b>Evaluation Provided By:</b>	
<i>Name:</i>	<i>Daytime phone:</i>
<i>Hospital/Organization Name:</i>	<i>Address:</i>

**Report is Based On** (circle one):

My knowledge of clinician is based on *close personal observation* / *general impression* / *other* : \_\_\_\_\_.

I have known them since \_\_\_\_\_.

**Evaluation**

**This evaluation should be based on demonstrated performance compared to that reasonably expected of a practitioner at his/her level of training, experience, and background.**

	Acceptable	Unacceptable	Unknown
Clinical Knowledge			
Technical/Clinical Skills			
Clinical Judgment			
Availability/Thoroughness in Patient Care			
Cooperativeness/Ability to work with others			
Record Keeping			
Ethical Conduct			

**Problem Areas**

Have you ever observed or been informed of any physical/mental/drug, or alcohol dependencies or other problems that the applicant has that have or could potentially impair his/her ability to exercise all or any of the privileges requested? (If yes please explain)

\_\_\_ No \_\_\_ Yes: \_\_\_\_\_

**Corrective Action**

During the in which you have known them, has this clinician ever been subject to any disciplinary action, such as admonition, reprimand, suspension, or termination? (If yes please explain)

\_\_\_ No \_\_\_ Yes: \_\_\_\_\_

**Summary**

Are there any reasons why you would not recommend this clinician? (If yes please explain)

\_\_\_ No \_\_\_ Yes: \_\_\_\_\_

**Comments** (Notable strengths and weaknesses) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature and Title Date

**PROFESSIONAL REFERENCES FOR PROVIDER**

Evaluation for: \_\_\_\_\_

<b>Evaluation Provided By:</b>	
<i>Name:</i>	<i>Daytime phone:</i>
<i>Hospital/Organization Name:</i>	<i>Address:</i>

**Report is Based On** (circle one):

My knowledge of clinician is based on *close personal observation* / *general impression* / *other* : \_\_\_\_\_.

I have known them since \_\_\_\_\_.

**Evaluation**

**This evaluation should be based on demonstrated performance compared to that reasonably expected of a practitioner at his/her level of training, experience, and background.**

	Acceptable	Unacceptable	Unknown
Clinical Knowledge			
Technical/Clinical Skills			
Clinical Judgment			
Availability/Thoroughness in Patient Care			
Cooperativeness/Ability to work with others			
Record Keeping			
Ethical Conduct			

**Problem Areas**

Have you ever observed or been informed of any physical/mental/drug, or alcohol dependencies or other problems that the applicant has that have or could potentially impair his/her ability to exercise all or any of the privileges requested? (If yes please explain)

\_\_\_ No \_\_\_ Yes: \_\_\_\_\_

**Corrective Action**

During the in which you have known them, has this clinician ever been subject to any disciplinary action, such as admonition, reprimand, suspension, or termination? (If yes please explain)

\_\_\_ No \_\_\_ Yes: \_\_\_\_\_

**Summary**

Are there any reasons why you would not recommend this clinician? (If yes please explain)

\_\_\_ No \_\_\_ Yes: \_\_\_\_\_

**Comments** (Notable strengths and weaknesses) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature and Title Date

**PROFESSIONAL REFERENCES FOR PROVIDER**

Evaluation for: \_\_\_\_\_

<b>Evaluation Provided By:</b>	
<i>Name:</i>	<i>Daytime phone:</i>
<i>Hospital/Organization Name:</i>	<i>Address:</i>

**Report is Based On** (circle one):

My knowledge of clinician is based on *close personal observation* / *general impression* / *other* : \_\_\_\_\_.

I have known them since \_\_\_\_\_.

**Evaluation**

**This evaluation should be based on demonstrated performance compared to that reasonably expected of a practitioner at his/her level of training, experience, and background.**

	Acceptable	Unacceptable	Unknown
Clinical Knowledge			
Technical/Clinical Skills			
Clinical Judgment			
Availability/Thoroughness in Patient Care			
Cooperativeness/Ability to work with others			
Record Keeping			
Ethical Conduct			

**Problem Areas**

Have you ever observed or been informed of any physical/mental/drug, or alcohol dependencies or other problems that the applicant has that have or could potentially impair his/her ability to exercise all or any of the privileges requested? (If yes please explain)

\_\_\_ No \_\_\_ Yes: \_\_\_\_\_

**Corrective Action**

During the in which you have known them, has this clinician ever been subject to any disciplinary action, such as admonition, reprimand, suspension, or termination? (If yes please explain)

\_\_\_ No \_\_\_ Yes: \_\_\_\_\_

**Summary**

Are there any reasons why you would not recommend this clinician? (If yes please explain)

\_\_\_ No \_\_\_ Yes: \_\_\_\_\_

**Comments** (Notable strengths and weaknesses) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature and Title \_\_\_\_\_  
 Date

# Request for Taxpayer Identification Number and Certification

**Give form to the  
 requester. Do not  
 send to the IRS.**

<b>Print or type See Specific Instructions on page 2.</b>	Name	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ .....	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	
City, state, and ZIP code		
List account number(s) here (optional)		
Requester's name and address (optional)		

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Social security number								
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> </tr> </table>								
or								
Employer identification number								
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> </tr> </table>								

**Note:** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
------------------	----------------------------	--------

## Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

**Note:** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Foreign person.** If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515**, Withholding of Tax on Nonresident Aliens and Foreign Entities).

## Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% after December 31, 2003; 28% after December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9**.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

**Other entities.** Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note:** *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

### Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note:** *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

**Exempt payees.** Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);
2. The United States or any of its agencies or instrumentalities;
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or
5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;
7. A foreign central bank of issue;
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

- 9. A futures commission merchant registered with the Commodity Futures Trading Commission;
- 10. A real estate investment trust;
- 11. An entity registered at all times during the tax year under the Investment Company Act of 1940;
- 12. A common trust fund operated by a bank under section 584(a);
- 13. A financial institution;
- 14. A middleman known in the investment community as a nominee or custodian; or
- 15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15**.

If the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for <b>9</b>
Broker transactions	Exempt recipients <b>1</b> through <b>13</b> . Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients <b>1</b> through <b>5</b>
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt recipients <b>1</b> through <b>7</b> <sup>2</sup>

<sup>1</sup> See **Form 1099-MISC**, Miscellaneous Income, and its instructions.  
<sup>2</sup> However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

**Note:** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office or get this form on-line at [www.ssa.gov/online/ss5.html](http://www.ssa.gov/online/ss5.html). You may also get this form by calling 1-800-772-1213. Use **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at [www.irs.gov](http://www.irs.gov).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note:** Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see **Exempt from backup withholding** on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

## What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> **You must show your individual name**, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

<sup>4</sup> List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

**Note:** *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.



# LifeWork Strategies/Your Advocate EAP Referral Confidential Fax

14915 Broschart Rd., Suite 250, Rockville, MD 20850 Phone: 301-315-3840 Fax: 301-315-3838

<b>To:</b>	<b>Fax Number:</b>
<b>From:</b>	<b>Pages:</b>
<b>Date:</b>	<b>Invoice #:</b>

1.) Case Number:

2.) Session Model:

3.) Client Name:

4.) Employer Name:

5.) Client Address:

6.) Client Phone:

7.) Client Age:

8.) Presenting Problem:

**SAMPLE:**

**YOU WILL RECEIVE THIS FAX WHEN GIVEN A REFERRAL**

## Getting Connected

1. Notify LWS of appointment date and time by emailing or calling referring counselor, or by calling the administrative clinical line **(301) 315-3840** and leaving a message.
2. Notify LWS if you do not hear from the client within two weeks.

## Counseling

1. Client must complete the Statement of Understanding and Personal History Form at first session.
2. Call LWS to confirm client attended first appointment.
3. Provide 1-3 assessment sessions followed by case review with LWS staff to determine:
  - Referral
  - Short-term EAP Counseling

## Case Closing

1. Follow-up with client two weeks after last session (follow-up is considered the case closing date).
2. Within **30 days** of case closing, submit the following paperwork to address above:
  - Statement of Understanding
  - Self Referral Form (if applicable)
  - Personal History Form
  - Invoice
  - Case Closing Form

Please follow these steps to ensure payment and/or continued referrals in the future.

*Notice of Confidentiality: The information included and/or attached in this transmission may contain confidential or privileged information and is intended only for the use of the addressee (s) named above. If you, the reader of this message, are not the intended recipient, you are hereby notified that any unauthorized dissemination, disclosure, reproduction, distribution or the taking of action in reliance on the contents of the information is prohibited. If you believe that you have received this fax in error, please notify the sender by reply transmission and destroy this document without copying or disclosing it.*

# PAPERWORK TO RETURN WHEN EAP CASE IS CLOSED

PLEASE MAKE COPIES FOR YOUR RECORDS

Mail back the following:

- Signed Statement of Understanding
- Completed Case Closing Form
- Completed Client Personal History Form
- Completed Invoice
- Any additional paperwork if applicable (*ROI, Self-Referral, etc*)

Mail To:

LifeWork Strategies, LLC  
14915 Broschart Rd, Suite 250  
Rockville, MD 20850

OR

Fax to (301) 315-3838

## Case Closing Form

- Make a follow up call within two weeks of completing the final session
- All paperwork must be submitted within **30 days** of case closing to ensure payment
- This form must be submitted with completed **Invoice, Personal History Form, and Statement of Understanding**

Today's Date \_\_\_\_\_ Case #: \_\_\_\_\_ Client Name: \_\_\_\_\_

Client Company: \_\_\_\_\_ Date of clinical consult with Advocate Staff: \_\_\_\_\_

# of sessions used: \_\_\_\_\_ Date of case closed: \_\_\_\_\_ Date F/U call (case closing): \_\_\_\_\_

Additional People in Session:

Name	Date	Relationship to Client

Assessed Problem: Please **SELECT ONE**

Marital/Couples	Family	Occupational	Emotional
Medical	Parent/Child	Addiction (specify):	Mood
Another's Addiction (specify):	Another's Emotional/Physical	Trauma	Behavioral
Grief/Loss	Anxiety	Life Transitions	Interpersonal Relationship
Violence	Eating D/O	Other:	

Explanation of Assessed Problem:

Outcome in workplace if applicable (client report from two week follow-up):

Counseling Goals: 1.)

2.)

3.)

Were counseling goals achieved? Yes No Partly

Presenting GAF: \_\_\_\_\_ Closing GAF: \_\_\_\_\_

**EAP Outcome (Decision made at the end of EAP consultation sessions. Check all that apply):**

- Community Education:** \_\_\_\_\_
- Self Help:** \_\_\_\_\_
- Other:** \_\_\_\_\_
- Other EAP Services:** (Circle all that apply)  
Child Care      Financial      Wellness Coaching      Legal      Elder Care
- Transition to Long Term Treatment:** (Circle all that apply)  
Self Referral (if yes, please submit self referral form)      Outside Outpatient Referral  
Inpatient      Partial Residential

Did the client follow through with referral(s)?  Yes  No  Unknown

**Treatment Referral: Provider Information (only if referring into insurance)**

Clinician: \_\_\_\_\_ Credential: \_\_\_\_\_

Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

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

**Treatment Referral: Provider Information (only if referring into insurance)**

Clinician: \_\_\_\_\_ Credential: \_\_\_\_\_

Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

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

**Additional Comments:**

Counselor Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

## STATEMENT OF UNDERSTANDING

Case # \_\_\_\_\_

You have voluntarily chosen to use the benefit provided by your Employee Assistance Program (EAP).

You are eligible for up to \_\_\_\_\_ sessions with your counselor. However, the number of sessions received will be based on clinical need and is to be determined by you and your counselor. If your reason for contacting EAP cannot be adequately addressed within the allotted number of sessions, you will be referred out of EAP for further assistance. This referral typically occurs between sessions 2 (two) and 3 (three).

This EAP program is provided to you at no cost. However, you may incur costs if you are referred to a treatment provider when deemed appropriate following the assessment by the EAP counselor. Any referrals will be made with careful consideration of your insurance benefits and economic situation.

The EAP program is a confidential service. Information disclosed during your counseling session will only be communicated outside of the EAP under the following circumstances: 1) you consent in writing; 2) your life or safety is seriously threatened; 3) the life or safety of others is seriously threatened; 4) disclosure is required by law; and/or 5) there is an admission of child abuse.

I, (*name*) \_\_\_\_\_ understand the information printed above and will participate in the EAP program under the terms specified above.

\_\_\_\_\_  
Signature (client) Date

\_\_\_\_\_  
Signature (counselor/witness) Date

**PERSONAL HISTORY FORM**  
(Completed by Client)

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

What concern(s) brings you to counseling?

\_\_\_\_\_

What changes would you like to see as a result of counseling?

\_\_\_\_\_

**Previous Counseling, EAP or Chemical Dependency Services:**

Counselor	Date	Reason	Helpful?
1			
2			
3			

**Household Members:**

Name	Age	Relationship	Are you the legal custodian/guardian?
1			
2			
3			
4			
5			

**Medical History**

Are you currently under a doctor's care?		Yes	No	Health Problems: (include allergies)	
: date of last physical exam					
: name of Primary Care Physician					
: other doctor(s) involved in your care					

**Medication currently using: (if none, state none)**

Medication	Dosage	Doctor Prescribing	Reason Prescribed

**Past Hospitalizations - Medical, Psychiatric, Chemical Dependency:**

Date	Reason	Hospital

# INVOICE

Invoice must accompany case closing paperwork

Invoice Date: \_\_\_\_\_ Invoice Number (Case Number): \_\_\_\_\_

**EAP Counselor Information:**

Counselor's Name: \_\_\_\_\_

Agencies Name: \_\_\_\_\_  
(If applicable)

Billing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Remit Invoices To:

**Your Advocate**  
14915 Broschart Rd  
Suite 250  
Rockville, MD 20850

Phone#: \_\_\_\_\_ Tax ID# \_\_\_\_\_ NPI# \_\_\_\_\_

Please check the appropriate boxes in the grid below to indicate the status for each appointment.

Date	Attended	Late Cancellation	No Show
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR ADVOCATE OFFICE USE ONLY

**CHECK MESSAGE:** \_\_\_\_\_

Sessions Used: \_\_\_\_\_ Rate: \_\_\_\_\_ Total: \_\_\_\_\_

Clinical Supervisor Approval	APPROVED FOR PAYMENT (NET 30)
	Signature: _____
	Date: _____ Amount: _____
	Unit                      Department                      Account #
	1   0   7   9   0   0   0   5   8   7   0   0

## ADDITIONAL PAPERWORK IF APPLICABLE

PLEASE MAKE COPIES FOR YOUR RECORDS

- Release of Information
- Self-Referral Form



Your Advocate for Employee Assistance, Work/Life and Workplace Wellness Programs

Authorization for Release of Information

I, \_\_\_\_\_ give my permission to LifeWork Strategies/Your Advocate (Employee's name)

\_\_\_\_\_ to disclose information and/or to \_\_\_\_\_ obtain information from \_\_\_\_\_ (Employer name)

Only the following information may be communicated:

- \_\_\_\_\_ Mental health evaluation \_\_\_\_\_ Progress notes
\_\_\_\_\_ Treatment recommendations \_\_\_\_\_ Treatment plan
\_\_\_\_\_ Compliance with treatment \_\_\_\_\_ Referrals to other professionals
\_\_\_\_\_ Participation/Attendance information \_\_\_\_\_ Case closing notes
\_\_\_\_\_ Diagnosis \_\_\_\_\_ Other: \_\_\_\_\_

The purpose of this release of information: \_\_\_\_\_

This release of information expires one year from the below date and may be revoked by me at any time.

Signature (client) Date

Signature (counselor/witness) Date

Notice to recipient of information: This information has been disclosed to you from records of confidentiality of which may be protected by federal and/or state law. If the records are so protected, 42 CFR Part 2, prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2.

## PROVIDER SELF REFERRAL FORM

*When pursuing a provider self referral with a LifeWork Strategies, Your Advocate EAP client, please understand the following:*

1. The client is eligible to use the contract specific number of EAP sessions; however,
2. If a self referral from EAP to MHSA is necessary, the request should be determined no later than the 3rd EAP session.
3. The client must be offered several referral options.

### R E F E R R A L   S T A T E M E N T

I, \_\_\_\_\_ (counselor) am treating \_\_\_\_\_ (client) through LifeWork Strategies, Your Advocate EAP. My clinical assessment indicates that the above client will require continuation of treatment beyond the allotted EAP sessions. I have discussed referral options with my client. Understanding the conditions listed above and in the best interest of the client, it is appropriate to continue the therapeutic relationship after the EAP case closing. Below is an outline of at least two cost-effective resources (*not including continuation of care with current counselor*) that were provided to the client:

- 1.
- 2.
3. Self Referral

By signing below, the client hereby declines the options listed above and chooses to continue treatment with \_\_\_\_\_ (counselor). Both the client and counselor understand that all sessions starting \_\_\_\_\_ (date) will not be paid by LifeWork Strategies, Your Advocate EAP; therefore, all financial responsibilities move to the client.

\_\_\_\_\_  
(Counselor Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Client Signature)

\_\_\_\_\_  
(Date)