



Adult Client Information -- Employee Assistance Program

***All identifying information is confidential, to the extent permitted by law.**

Today's Date: _____ **Been Here Before?** Yes No **When?:** _____

Name: _____ **Preferred Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephones: Cell: _____ **Home:** _____ **Work:** _____

OK to text an appointment reminder? Yes No

OK to Call?: Cell Home Work **OK to Leave Message?:** Cell Home Work

Email: _____ **OK to email?:** Yes No

Date of Birth: _____ **Age:** _____ **Gender:** _____

Marital Status: Single Divorced Widowed Married Partnered

Name of Spouse/Partner: _____ **How long married?:** _____ **Kids?:** _____

Emergency Contact: _____ **Phone number:** _____

Your Employer: _____

Job Title: _____ **Dept.:** _____

Referred by: Self Supervisor HR Co-worker/Friend Family

Have you ever received any kind of counseling services? Yes No

When: _____ **Therapist:** _____

The information below pertains to the Employee of the company providing this benefit.

Your status with the Employee of the company that is sponsoring this EAP visit:

Self Spouse Partner Child/Dependent of Employee

Name of Company Providing this Benefit: _____

Employee Name: _____ **Employee's Date of Birth:** _____



Statement of Understanding -- Employee Assistance Program

Welcome to the Employee Assistance Program (EAP). Your employer sponsors this EAP to help employees and family members resolve personal problems.

SERVICES:

Your EAP counselor will help evaluate your situation and develop an action plan for resolving the problem. This action plan may include additional EAP sessions (up to the limits of your company's contract with us), or you may be referred to providers outside of the EAP who have expertise in your area of need.

The EAP **does not provide** long-term therapy; neither does it provide specialized evaluations such as psychological testing, custody evaluations, or court-ordered evaluations. However, we will help you identify appropriate resources to meet these needs.

CONFIDENTIALITY:

EAP services are confidential. We will not reveal information about our work with you to any outside person or agency, including your employer, without your written permission. The only exception to confidentiality is by court order, or in those situations that are life threatening, involve suspected abuse or neglect of a child or vulnerable adult, or represent the commission or threat of a crime on the EAP premises.

COSTS AND APPOINTMENTS:

EAP services are customized by the employer and usually are paid in full by the employer. Some plans may require copay after a certain number of visits. Your counselor will be able to explain the details of your plan. If you accept a referral to a provider in the community, you will be responsible for any costs associated with those services. You should check your health care benefits to determine if those costs might be covered by your health insurance.

EAP sessions will usually last 45-60 minutes. Your counselor will make every effort to begin and end the sessions on time. **If you fail to appear for a session, or cancel a session with less than 24 hour notice, we will either count that session against the total allowed by the employer or you may be charged for the time that was allotted to you, depending on your plan.** Your counselor will be able to answer questions about this policy.

THE SAINT ALPHONSUS EAP:

The Saint Alphonsus EAP is a department of Saint Alphonsus. All counselors have earned advanced degrees and maintain state licenses. If you have additional questions about the EAP, ask your EAP counselor or the Office Manager.

FEEDBACK QUESTIONNAIRE:

In order to monitor the effectiveness of the EAP and identify ways of improving our services. After we complete our work together, we would like to send you an anonymous feedback questionnaire. Please select from the following options:

- Please email the questionnaire to the following address: _____
- Please mail the questionnaire to the following address: _____
- No, please do not send me a feedback questionnaire.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

I have been offered the Saint Alphonsus Notice of Privacy Practices that provides information about how the facility may use and disclose Protected Health Information (PHI) for purposes of treatment, payment, and health care operations.

Please initial: _____

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge that the Patient Rights and Responsibilities brochure was offered to me and is available in the registration area and upon request. I understand the brochure includes information about visitation rights, Advance Directives, as well as information regarding other patient rights and responsibilities.

Please initial: _____

I have read this statement and accept, understand, and acknowledge its conditions and contents.

Signature of Client or Legal Guardian

Date

Name of Client (Please Print)

Date of Birth

Non-Discrimination Notice

Saint Alphonus Health System, Inc. honors the sacredness and dignity of every person, complies with applicable Federal civil rights laws, and does not discriminate on the basis of protected classes, including but not limited to age, race, skin color, national origin (including ethnicity, culture, or language), religion, physical or mental disability, socioeconomic status, or sex (including sexual orientation, gender identity, or gender expression).

Saint Alphonus Health System, Inc.:

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
 - Qualified sign language interpreters
 - Written information in other formats such as large print, audio, accessible electronic and other formats
- **Provides free language services to people whose primary language is not English, such as:**
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact our Community Services Coordinator at 1-866-727-6248.

If you believe that Saint Alphonus Health System, Inc. has failed to provide these services or discriminated in another way on the basis of age, race, skin color, national origin (including ethnicity, culture, or language), religion, physical or mental disability, socioeconomic status, or sex (including sexual orientation, gender identity, or gender expression), you can file a grievance in person, by mail, fax or email to:

- Patient Relations Coordinator
1055 N Curtis Road, Boise, Idaho 83706
- Phone: 208-367-6226 | Fax: 208-367-8181
- Email: BO-PatientRelations@saintalphonus.org

If you need help filing a grievance the Patient Relations Coordinator is available to help you. You can also file a civil rights complaint with the US Department of Health & Human Services, Office for Civil Rights electronically via web, by mail or phone to:

- US Department of Health & Human Service 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201
- Web: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- Phone: 1-800-368-1019 | TTY 1-800-537-7697



Saint Alphonus
A Member of Trinity Health

Non-Discrimination Notice

Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات الترجمة اللغوية تتوافر لك بالمجان. اتصل بالرقم: 1-866-727-6248 , (رقم هاتف الصم والبكم: 1-844-801-7932)

Burmese

သတိ။ သင် [ဗမာစကား] ပြောရင် ဘာသာစကားအတွက် အကူအညီပေးတဲ့ဝန်ဆောင်မှု အခမဲ့ရနိုင်ပါတယ်။ 1-866-727-6248 TTY: 1-844-801-7932 ကို ဖုန်းဆက်ပါ။

Chinese

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-866-727-6248 TTY: 1-844-801-7932。

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-2397-108-448 فراموشی نباشد. 1-8426-727-668

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-727-6248 ATS : 1-844-801-7932.

Japanese

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-866-727-6248 TTY: 1-844-801-7932 まで、お電話にてご連絡ください。

Karen

တၢ်သ့ၣ်တၢ်သး: မ့ၢ်န့ၣ်တၢ်ပုၤကညိၣ်ကိၣ်အကိၣ်လိၣ်တဲၣ်နီၣ်ဂံၢ် 8426-727-668-1 TTY: 2397-108-448-1. မၤစၢၤနီၣ်သ့ၣ်တၢ်မ့ၢ်အကလိၣ်.

Kirundi

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-866-727-6248 TTY: 1-844-801-7932.

Korean

안내: [한국어] 를 사용하시는 경우 언어 지원 서비스를 무료 이용하실 수 있습니다. 1-866-727-6248 (TTY : 1-844-801-7932) 로 전화해 주십시오.

Nepali

ध्यान दिनुहोस्: तपाइंले नेपाली बोलनुहुन्छ भने तपाइंको नमिर्त भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-866-727-6248 टिक्किहः 1-844-801-7932 ।

Pashtu

خدمات مرستی وړیا ژبی د ،کوی خبرې ژبه پښتو په تاسو که پاملرنه ونیسی اړیکه شمیری دی په .دي چمتو ته تاسو

Romanian

Atentie: Daca vorbesti [Romania], serviciul de asistanta lingvistic, fara plata, este la indemana ta (disponibil). Suna la Telefonul acesta 1-866-727-6248 sau 1-844-801-7932

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-727-6248 телетайп: 1-844-801-7932.

Serbo-Croatian

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-727-6248 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-844-801-7932.

Somali

DIGNIIN: Haddii aad ku hadasho [luqadda ku dar], adeegyada ka caawinta luqadda, oo lacag la'aan ah ayaa lagu heli karaa. Wac 1-866-727-6248 (TTY: 1-844-801-7932).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-727-6248 TTY: 1-844-801-7932.

Swahili

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata huduma za lugha, bila malipo. Piga simu 1-866-727-6248 TTY: 1-844-801-7932.

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال 1-866-727-6248 کریں 1-844-801-7932

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-727-6248 TTY: 1-844-801-7932.



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Client Name: _____

Date: _____

Summary List -- Employee Assistance Program

ALLERGIES Adverse Drug Reaction	SUBSTANCE	REACTION

CURRENT MEDICATIONS/DATES

SIGNIFICANT MEDICAL OR PSYCHIATRIC ILLNESS

Signature: _____