

APPENDIX E

Employee Assistance Program (EAP) Forms





Provider Attestation for EAP Specialty Services

CIGNA supports the concept that all licensed behavioral health providers, by virtue of their license, are competent to treat most behavioral health disorders. CIGNA also supports that some disorders, treatment modalities, special services, and/or patient population groups are better treated by providers with special knowledge and skills in such areas. We recognize that the special knowledge and skills can be gained through various types of education as well as through experience.

This attestation is for providers who are qualified to provide EAP specialty services for CIGNA's Employee Assistance Program (EAP) customers. If you meet the qualifications and would like to have these specialties loaded into your CIGNA Provider Profile, please complete and return this form to Network Operations at (860-687-7257). To claim a specialty in one of the CIGNA EAP Specialties you must meet all of the conditions for each specialty. If for any reason you do not meet all of the conditions but feel you should be considered for one or more of these specialties please document your rationale in the Provider Comments Section at the end of this document.

PLEASE PRINT LEGIBLY:

Name/Licensure: _____

Address, City, State, Zip: _____

Office Phone: _____ Emergency (pager/cell): _____

Critical Incident Response Phone (if applicable): _____

EAP Assessment & Referral Services

I attest that:

- I am qualified and available to perform short term counseling that focuses on problem identification and resolution and/or referral to an appropriate resource to complete the problem resolution.

Certified Employee Assistance Professional (CEAP)

I attest that:

- I hold a current CEAP certification granted by the Employee Assistance Certification Commission (EACC).

Critical Incident Response (CIR)

The EAP makes available on-site or telephonic support to managers and/or employees after a traumatic or tragic event that affects the workplace. The goal is to return the employees to normal, productive functioning as quickly as possible after the traumatic experience. These sessions occur at the workplace, and CIGNA has prepared informative handouts on a number of related topics for distribution at these meetings.

I attest that:

- I have received formal training in Critical Incident Response
- I have delivered a minimum of four (4) CIR services in the past two years
- I agree to make changes in my schedule to accommodate CIR requests within 2-12 hours

Employee Educational Seminars (e.g. Employee Wellness Trainings @ the Workplace)

This category includes on-site health promotion/wellness seminars that address common personal or work-related concerns (stress management, conflict resolution, preventing violence and harassment in the workplace). All seminars are already prepared by CIGNA with detailed speaker's notes, Power Point presentations, and participant handouts.

I attest that:

- I have presented a minimum of four (4) Employee Wellness Seminars in the past two (2) years**
- I agree to make changes in my schedule to accommodate requests within 3-4 weeks
- I am knowledgeable in presenting seminars utilizing PowerPoint
- I can access CIGNA EAP educational information electronically - via email or CD

EAP Management Referrals

This refers to situations when a Manager or HR refers an employee to the EAP when there are job performance issues. A Management Referral consists of a voluntary assessment through the EAP and consent for CIGNA to communicate compliance and recommendations with the referring Manager. EAP practitioners who accept management referrals are expected to work directly with the assigned CIGNA EAP Consultant.



If I check this box, I attest that:

- I am experienced with clients who are required to access services
- I agree to assess an employee and develop a plan to address his or her issues that may be contributing to the workplace problem
- I am qualified and agree to perform a general substance abuse screening as part of my overall assessment
- I am familiar with local resources and agree to serve as an advocate for the client in accessing the proper level of care
- I agree to follow up with referral resources to verify initial compliance with recommended treatment
- I agree to follow up within 24 hours of each appointment with the CIGNA EAP Consultant who referred the case to me

SAP - Substance Abuse Professional Certification as defined by the Department of Transportation (DOT)

NOTE: - Substance Abuse Licensure or Certification through your State or National Entity (CAC, CADAC, LCDC, etc.) is not sufficient and does not meet the criteria for this level of service.

If I check this box, I attest that:

- I have successfully completed a qualified training course recognized by the Department of Transportation (DOT)
- I have satisfactorily completed a post-training examination administered by a nationally recognized professional or training organization recognized by the DOT.
- I hold a current certificate that indicates I have met all of the DOT requirements (effective 1/1/04) for practice as a SAP and am qualified to use the title of SAP as defined by the DOT.

SAE - Substance Abuse Expert Certification as defined by the Nuclear Regulatory Commission (NRC)

NOTE: - Substance Abuse Licensure or Certification through your State or National Entity (CAC, CADAC, LCDC, etc.) is not sufficient and does not meet the criteria for this level of service.

If I check this box, I attest that:

- I have successfully completed a qualified training course recognized by the Nuclear Regulatory Commission (NRC)
- I have satisfactorily completed a post-training examination administered by a nationally recognized professional or training organization recognized by the NRC.
- I hold a current certificate that indicates I have met all of the NRC requirements (effective 03/15/10) for practice as a SAE and am qualified to use the title of SAE as defined by the NRC.

Supervisory Training Sessions @ the Workplace

Supervisor trainings equip managers a) with the tools needed to recognize, manage and assist employees to improve job performance issues and b) how to understand the EAP – its benefits, how to use it as a management tool, and how to successfully refer employees. Sessions usually occur at the Employer site and presentations are already prepared by CIGNA to include: detailed speaker’s notes, Power Point presentations, and participant handouts.

If I check this box, I attest that:

- I am familiar with the management referral process, including the roles of the manager, the EAP consultant, and the counselor
- I have delivered a minimum of four (4) Supervisor Training sessions in the last two (2) years
- I agree to make changes to my schedule to accommodate these requests within 2-4 weeks
- I am knowledgeable in presenting seminars utilizing PowerPoint
- I can access CIGNA EAP educational information electronically - via email or CD

Provider Comments: *Please include any other information about your EAP experience and/or qualifications that might not be listed above.*

I hereby certify and attest that all of the information above is true and accurate. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from CIGNA’s behavioral provider network. Furthermore, I understand that CIGNA maintains the right to deselect EAP specialties at its discretion.

Provider Signature

Date



Employee Assistance Program (EAP) STATEMENT OF UNDERSTANDING

Employee Assistance Programs (EAPs) are provided by many employers who wish to offer their employees and family members a professional assessment and referral service. This information is provided to you to help you better utilize available EAP services.

Fees

Sessions within the EAP are offered at no cost to the employee or family members. Your employer has already paid for this service.

If an employee or family member needs specialized counseling or treatment services, he or she will be assisted in locating an appropriate resource. While medical benefits may defray some of the costs of the services provided by these resources, the employee or family member assumes financial responsibility for such services.

Privacy

Information concerning the use of the EAP will not be given to anyone outside the EAP without your permission unless required by law. Certain state laws require that the EAP staff assume the responsibility for reporting to appropriate parties instances when a person is a danger to him or herself, to others, or when child or vulnerable adult abuse/neglect is involved.

Self-referrals

If an employee or family member initiates a request for assistance, no one will be notified of the individual's use of the EAP service without that individual's written permission.

Supervisor referrals

If a supervisor initiates the referral of an employee as the result of a performance discussion, or as a result of a positive drug screen, the supervisor will be notified whether or not the employee has kept the appointment with the EAP professional.

Voluntary participation

Use of the EAP is voluntary. It is the client's decision whether to use (or not to use) the services available. In some cases, as noted above, your employer may require participation in the EAP as a condition of employment or as a part of the company's substance abuse policy.

Complaints and grievances

If you have a complaint concerning a person associated with CIGNA's EAP, an EAP service, the quality of services, or any other aspect of the EAP, you may register the complaint with our Customer Service Department by calling 800-926-2273.

I have read and received a copy (if requested) of this information.

Signature

Date



AUTHORIZATION FOR USE AND DISCLOSURE OF PRIVATE AND CONFIDENTIAL HEALTH INFORMATION

THIS FORM WILL ALLOW CIGNA *, INC. TO RELEASE THE PRIVATE HEALTH INFORMATION SPECIFIED BELOW TO THE PERSONS OR ENTITIES SPECIFIED ON THIS FORM.

Description of Private Health Information to be released:

1. Attendance or Non-Attendance at EAP session(s). Information will not include diagnostic or clinical disclosure
2. Suggestions, if any, resulting from the EAP assessment regarding workplace/supervisory strategy that may support improved work performance. Information will not include diagnostic or clinical disclosure.
3. Recommendation(s), if any, resulting from the EAP assessment. Information shall be limited to identifying the **level of care:** (outpatient, partial hospitalization, inpatient or residential), **type of referral resource(s):** (self-help, support groups, medical evaluation, etc.), the **name of the treating practitioner and/or facility if requested for purposes of ongoing follow-up.** Information will not include diagnostic or clinical disclosure
4. The estimated time frame necessary to complete the recommendation(s). Information will not include diagnostic or clinical disclosure.
5. The employee's demonstrated compliance or non-compliance with initial follow-through of the recommendation(s).
6. Information will not include diagnostic or clinical disclosure

Verification

Identification of person authorizing release: (Accuracy and completeness is needed for this document to be valid.)

Please complete all applicable items

| | | | |
|----------------------------|----------------------|---|--|
| Name of Participant | Date of Birth | Participant's Social Security Number | |
|----------------------------|----------------------|---|--|

| | | | |
|-----------------------|-------------|--------------|------------|
| Street Address | City | State | Zip |
|-----------------------|-------------|--------------|------------|

Participant's Employer Name

I authorize the persons or entities below to receive the information

| | | | |
|-------------|-----------------------------|---------------------|--|
| Name | Title and Department | Phone number | |
|-------------|-----------------------------|---------------------|--|

| | | | |
|-----------------------|-------------|--------------|------------|
| Street Address | City | State | Zip |
|-----------------------|-------------|--------------|------------|

Purpose of this release of information:

To confirm the employee's compliance with the process for formal management or continuation of employment referrals to the EAP and to assist in restoring optimal job performance.

This document will expire 60 days following discharge from and/or completion of treatment or education as recommended by the EAP provider.

I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

I understand that if information on this form is not complete, CIGNA will return the form to me, and this request will not be considered until CIGNA has received all the required information.

I understand that I may revoke this authorization by sending a written request to CIGNA, EAP, 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344

You can obtain a form to revoke the authorization by calling CIGNA customer services at: 800.433.5768. Any revocation will not be effective for any actions CIGNA may already have taken.

Signature



I have read and understand the above information:

Signature

Date

Relationship if person signing is other than Participant

Note that: If not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If this request is made by a Parent/Guardian, complete the following: Participant is a minor, _____ years of age.

Age

If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

The provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization.

It is recommended that you keep a signed copy of this authorization for your records, however a copy of this signed authorization can be provided upon your request.

If the information disclosed to you relates to substance abuse treatment, in addition to HIPAA Privacy regulations, these confidential records' are protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the privacy of patients' records, and may be more restrictive than applicable federal regulations.

Please Return This Completed Form To:

CIGNA
Employee Assistance Program
11095 Viking Drive, Suite 350
Eden Prairie, MN 55344
Facsimile: 952-956-7100
Staff Person's Name:
Staff Person's Telephone Number: 800-241-4057 x

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare of Virginia, Inc. and CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.



**Employee Assistance Program (EAP)
WAIVER OF FINANCIAL RESPONSIBILITY FOR TREATMENT**

I _____ understand that my last assessment and consultation sessions
Participant
provider by _____ on behalf of the CIGNA EAP
CIGNA EAP Affiliate
was on _____ .
Date

I also understand that the CIGNA EAP is making an exception to
CIGNA EAP policy allowing _____ to provide
CIGNA EAP Affiliate
treatment beyond the CIGNA EAP assessment.

I further understand that all treatment sessions provided
by _____
CIGNA EAP Affiliate

after the aforementioned date will not be reimbursed on behalf of the CIGNA EAP and
are, therefore, my sole responsibility and will not be paid for in any part by the CIGNA
EAP.

Participant Date

CIGNA EAP Affiliate Date