



Navigating Work...Life...Health

Affiliate Packet


LYTLE EAP PARTNERS
Navigating Work...Life...Health

Introduction

Lytle EAP Partners is an independent consulting and service organization that provides development, implementation, and administration of behavioral care programs to business, industry, and various other organizations. Lytle EAP Partners provides a full range of integrated Employee Assistance and Wellness Programs including: Employee Assistance Programs (EAP), Member Assistance Programs (MAP), Substance Management Programs, Critical Incident and Crisis Services, Work/Life Programs, and Wellness Programs.

Lytle EAP Partners' purpose is to provide consultation and program services to our clients in the areas of behavioral healthcare. The cornerstone of all Lytle EAP Partners programs is responsive customer service and the delivery of direct clinical services.

Disclaimer

The information contained in this packet is for informational purposes only, and is not intended to be nor shall be construed as any type of contract. The information provided in this packet is subject to change at any time. Any contractual relationship which any affiliate may form with Lytle EAP Partners is stated solely by the terms and conditions of the Affiliate Agreement and Business Associate Agreement, copies of which will be given to affiliate. (The agreements may change from time to time.)

Procedural Flow Chart

1. Employee or family member calls Lytle EAP Partners (Lytle).
2. Lytle's Intake Counselor completes brief intake.
3. Lytle contacts Affiliate and provides Affiliate with client information.
4. Affiliate contacts client and offers an appointment with client to be held within the next three days.
5. Affiliate contacts Lytle to inform Lytle of the time the counseling appointment is scheduled.
6. Affiliate conducts assessment with client.
7. Affiliate calls Lytle to provide assessment information and determination if case is appropriate for short term services. If so, Lytle authorizes further sessions.
8. The affiliate will make appropriate referrals to a long-term provider, treatment center, support group, or other community resource following the assessment, and on an as needed basis through the conclusion of the service.
9. Affiliate sends Lytle the required client information, signed forms, and billing invoice no later than 45 days from the service date(s) to:
Lytle EAP Partners
Attention: Clinical Intake Department
200 Cedar Ridge Drive, Suite 208
Pittsburgh, PA 15205
10. Affiliate follows up with client, as needed.
11. Affiliate receives payment from Lytle within 45 days of Lytle's receipt of completed and approved information.

PLEASE DO NOT STRAY FROM THIS PLAN WITHOUT FIRST CONTACTING LYTLE EAP PARTNERS.

Affiliate Scope of Services

Scope of Services:

In addition to EAPA's Standard of Care, an Affiliate shall provide the following services in the manner indicated:

1. Affiliate's activity will be focused on assessment, short term (EAP) counseling, and when appropriate, referral of clients to community resources in such a manner as to maximize the client's ability to address and resolve his/her problem(s).
2. Affiliate will collect and record pertinent information about the client, including health history, family status, and other data deemed appropriate for the determination of the nature of the problem(s). Particular attention will be given to assessing alcohol and/or other drug problems.
3. Affiliate will require each client to sign a Lytle "Statement of Understanding", a "Release of Information" (as needed), and an "Acknowledgement of Receipt of Notice Of Privacy Practices".
4. Following the professional assessment, if referral to a community resource is appropriate, Affiliate will discuss the range of referral options, including self-help groups, with the client. Cost to the client and benefit coverage should be discussed at this time.
5. Affiliate will NOT contact the client's supervisor or anyone else at the client's place of employment.
6. Affiliate will make arrangements for the voluntary utilization of a referral resource, when appropriate, and encourage/motivate the client to follow through.
7. Affiliate will participate in and actively cooperate with Lytle's utilization review, case management and quality assurance programs, including, but not limited to, the performance of on-site concurrent review and case management as requested.
8. Affiliate will make every effort to have services accessible and responsive to the needs of all clients. Affiliate will be available for calls from Lytle and clients. Affiliate will have a live answering service, pager, or answering mechanism to facilitate immediate response when necessary.
9. Under emergency conditions, Affiliate will provide an immediate appointment. Under non-emergency conditions, Affiliate will offer an appointment for a client who requests it within three days of the time the client makes contact with Affiliate or Lytle, or any time mutually agreed upon and convenient to the client.

10. Affiliate will make every effort for client appointments to be scheduled on an extended workday basis. Weekend scheduling will be provided if necessary.
11. Affiliate will be responsible for the selection of community resources and subject to Lytle's approval.
12. Affiliate warrants that referral resources will conform to all licensing and certification requirements as designated by government agencies and professional associations for the performance of services offered.
13. Organizations may not refer to themselves. The exception may be if there is no other available resource. Exceptions must be pre-approved by Lytle.

Credentialing Procedure

Affiliate must be interviewed by a Lytle EAP Partners clinician to begin the process of joining the network. Following approval, the Affiliate must complete the credentialing procedure.

The following is a list of the paperwork required from each provider;

1. Completed:
 - a. Affiliate Update Form
 - b. Affiliate Demographic Form
 - c. W9 Form

2. Copy of:
 - a. Current Resume
 - b. Updated Liability Insurance
 - c. License (if applicable)

3. Keep copies of the Lytle EAP Partners' Affiliate Packet on file and make copies as needed.
Or, visit the Lytle EAP Partners' website, lytleep.com, to print forms as needed.

Affiliate Update Form

Please help us keep your file accurate for making referrals by completing the following information.
Thank you!

NAME (Clinician/Organization): _____

LOCATIONS: *(Be Sure To Include Zip Code)

Address:	Address:
Zip:	Zip:
Phone #:	Phone #:
Fax #:	Fax #:

Address:	Address:
Zip:	Zip:
Phone #:	Phone #:
Fax #:	Fax #:

Address:	Address:
Zip:	Zip:
Phone #:	Phone #:
Fax #:	Fax #:

If an organization with individually contracted clinicians, please list clinicians and their location below:

<u>Therapist</u>	<u>Location</u>
_____	_____
_____	_____
_____	_____
_____	_____

NOTE: Please send current verification of clinicians' licensing and liability insurance, if you have not done so in the last 6 months.

Affiliate Demographic Form

Please complete this page on the agency as a whole, or make copies and complete for each contracted clinician if appropriate.

Name: _____

Gender: M / F

Email Address: _____

Ethnicity:

African-American	
American Indian	
Asian	
Caucasian	
Hispanic	
Interracial	
West Indian	
Other	

Language Specialties:

Spanish	
French	
German	
American Sign Language	
Other	

Religion:

Christian	
Jewish	
Moslem	
Other	

Provides: Individual Group Family Couples CISD

REC Specialties:

African-American	
Asian	
Christian	
Homosexuality	
Hearing Impaired	
Hispanic	
Jewish	
Native American	
Other	

Clinical Specialties:

Adjustment Disorder		EMDR	
Adolescence/Family		Financial/Legal Resources	
Adoption		Geriatric Issues	
Adult Sexual Abuse		Infertility	
AIDS and HIV		Loss and Bereavement	
Alcohol and Drug Treatment & Related Issues		Men's Issues	
Anxiety Disorders		Mood Disorders	
Attention Deficit/Hyperactivity		Neurological Disorders	
Child Abuse – Sexual/Physical/Emotional		Occupational/Career	
Childcare		Police/Fire	
Children/Family		Post Traumatic Stress Disorders	
Chronic/Terminal Illness		Psychological Testing	
Couples/Marital		Stress Management	
Domestic Violence		Thought Disorders	
EAP		Women's Issues	
Eating Disorders		DOT SAP certified	
Eldercare		Fitness for Duty	
Gambling		Sign Language	
GLBT		Other	

Credentials:

CAC	
CEAP	
LPC	
LSW/LCSW/ACSW	
MD/DO	
Ph.D.	
SAP	

Trainings:

Drug Free Workplace	
Employee Orientation	
Supervisory Training	
Workshops	

Request for Taxpayer Identification Number and Certification

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

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	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"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. 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
or
Employer identification number

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. citizen or other U.S. person (defined below).

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.

Sign Here	Signature of U.S. person ▶	Date ▶
------------------	----------------------------	--------

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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.

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. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Client Information Forms

These forms include:

1. Statement of Understanding
2. Intake Assessment Form
3. Clinical Service Closing Form
4. Consent for Release of Information (to be used only if necessary)
5. Consent for Release of Information Supervisory Referral (to be used only if necessary)
6. Notice of Policies and Practices to Protect the Privacy of Your Health Information (client may keep)
7. Acknowledgement of Receipt of Notice of Privacy Practices
8. Invoice Form
9. Statement of Self-Referral/Waiver of Referral
10. Waiver of Referral Form

The Affiliate acknowledges that Lytle EAP Partners only agrees to pay for preapproved authorized sessions. Payment will be authorized to the Affiliate only when Lytle EAP Partners receives the appropriate paperwork and invoice no later than 45 days from the service date(s). Lytle EAP Partners will authorize payment to an Affiliate for actual services rendered within 45 working days of the Affiliate's completing the Lytle EAP Partners' receipt of the required documents.

Please make copies of the forms to keep on file or visit our website, lytleep.com, to print the forms as needed. Do not hesitate to call us if you have any questions regarding the completion of these forms at 1-800-327-7488 or 412-921-7000.

Statement of Understanding

Welcome to Lytle EAP Partners. An EAP (Employee Assistance Program) is a confidential resource designed to help individuals resolve problems and address concerns through professional counseling, consultation, assessment and referral, when necessary, to community resources.

Who pays for the service?: The services provided to you by Lytle EAP Partners are free of charge to you but prepaid by your employer. If you need a referral to a specialized service, those services will not be covered by your EAP benefit, but your EAP counselor will assist you in identifying services that take into consideration your health care benefit coverage and your ability to pay.

Attendance of EAP Sessions: Attending scheduled EAP appointment is important. Every effort will be made to offer you appointment times that are convenient. If you are unable to attend a scheduled session, we appreciate at least a 24 hour notice so that we may offer that time to others seeking assistance from the EAP.

Confidentiality: Lytle EAP Partners will maintain strict confidentiality regarding your sessions. Lytle EAP Partners' records are kept separate from your employer's and are accessible only to authorized Lytle EAP Partners staff. Information you share in the EAP will not be released outside the EAP without your written permission. The ONLY exceptions are when the information is required by law, such as in cases of child abuse, threat of harm to self or others, or by court order. Another exception could be when there is a threat to property.

Your signature below means that you have read this form and understand its content.

Signature of Client

Date

Signature of Client/Guardian (if applicable)

Date

Signature of Client/Guardian (if applicable)

Date

EAP Counselor

Date

- You have permission to mail a client satisfaction survey to my home.
- Do not mail a questionnaire to my home.

Lytle EAP Partners *Intake Assessment Form*

Clients Name:

Client Intake #:

Counselor/Affiliate Name:

Date(s) of Assessment:

Presenting Problem:

Describe Affect/Demeanor:

Describe any relevant family and/or social factors:

Describe Depressive Symptoms: (mood, loss of enjoyment, appetite, energy level, motivation, sleep):

Describe Anxiety Symptoms: (anxious, nervous, worrisome/fearful, panic):

Describe Suicide History: (none, ideation, intent, plan, actions, history):

Describe Homicidal History: (document risk, plan, intent, and counselor's action taken – including safety plan):

History of Violence: (description of any past violence, evidence of any domestic abuse – current, or past):

Other cognitive, behavioral, or emotional symptoms:

Clinical Service Closing Form Lytle EAP Partners

Client's Name: _____ SS#: _____ D.O.B. _____

Affiliate Provider Name: _____	Phone: _____	Date(s) of Assessment: _____
Address: _____		Fax #: _____

Date(s) of Service: _____
Date of Closing Session: _____
Disposition: (check one)
<input type="checkbox"/> Completed EAP No Referral <input type="checkbox"/> Client decision not to continue – Affiliate Agrees
<input type="checkbox"/> Completed EAP see Referrals <input type="checkbox"/> Client decision not to continue – Affiliate Disagrees
<input type="checkbox"/> Unable to contact client – no response to phone calls <input type="checkbox"/> Employment Terminated – No Longer Eligible

Referral Type	
Community Resource	Medical
Human Resource	Career Counseling
Substance Abuse – Inpatient	Self Help
Substance Abuse – Outpatient	Other
Independent Therapist	

If client was referred to individual provider, please provide resource

Referral #1	Referral #2
Name: _____	Name: _____
Phone: _____	Phone: _____

Self Referral Offered:
If self referral services are needed, Lytle EAP Partners requires that an EAP Affiliate: (1) contact Lytle EAP Partners and obtain authorization; (2) provide the client with at least two other referral sources; (3) have the client sign the referral waiver form and inform client of potential financial responsibility for referrals beyond EAP service.

Job Status At Close: (check one)	Benefits Used After EAP: (check one)	Problem Status Close: (check one)
Unchanged Resigned/Retired Terminated Disability Worker Compensation Other Don't Know	Mental Health Inpatient Mental Health Outpatient Medical Benefits None Available None Necessary Substance Abuse Inpatient Substance Abuse Outpatient	Resolved Improved Unchanged Worsened Don't Know

Required forms needed for closing final payment:	
Intake Assessment Statement of Understanding Release of Information (if needed)	Clinical Closing Form Treatment Waiver Form (if applicable) Invoices
Affiliate Signature: _____	Date: _____

**Consent for Release of Information
Clinical Referral**

I, _____(client name) authorize Lytle EAP Partners and its contracted affiliates (i.e. service providers) to exchange the following types of information for the following purposes.

Lytle EAP Partners may exchange with _____ the following information relating to the clinical services I receive to support continuity of care or to inform them of my status for any of the following:

- Social History _____,
- Medical Record _____,
- Treatment Summary _____,
- Psychological Evaluation _____,

And/or

Other _____ Explain: _____

The authorization shall become effective _____ and is subject to revocation in writing by me at any time, except to the extent that action has already been taken. This authorization shall terminate _____ from the effective date, if not earlier revoked. I understand that this information will be used only for the purpose noted above and will not be disclosed to any other person or agency without my written permission.

Signature of Client or Legal Guardian (circle which)

Date

Printed Name of Client

Date

Counselor's Signature

Date

Consent for Release of Information Supervisory Referral

I, _____(client name) authorize Lytle EAP Partners and its contracted affiliates (i.e. service providers) to exchange the following types of information for the following purposes:

I have been referred to the EAP by my employer and, in order to comply with the policies of my employer, I authorize Lytle EAP Partners to release the following non-medical information to my employer: (A) whether I have kept initial and/or subsequent appointments, (B) whether a course of treatment was recommended by the EAP counselor, (C) whether I am following the recommended course of treatment, and/or (D) whether I have completed the recommended course of treatment.

Other(Please Describe)

This authorization shall become effective _____and is subject to revocation in writing by me at any time, except to the extent that action has already been taken. This authorization shall terminate _____ from the effective date, if not earlier revoked. I understand that this information will be used only for the purpose noted above and will not be disclosed to any other person or agency without my written permission.

Signature of Client or Legal Guardian (circle)

Date

Printed name of Client

Date

Counselor's Signature

Date

Lytle EAP Partners

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW EAP INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Program Eligibility and Costs

Lytle EAP Partners offers assessment, referral, and short term counseling services. Services provided within the Assistance Program (AP) system are offered at no cost to you. Your organization has already paid for these services. If longer term counseling, community support services, specialized services or treatment is needed, referrals to services or providers outside of Lytle EAP Partners may be recommended to help you resolve problems. Those services may be offered at no cost (i.e., self-help groups) or covered under a medical benefit plan offered by an organization or insurer. However, it is your responsibility to determine whether or not services are covered under any such plan. Charges for any services provided by an outside community resource are your responsibility.

II. Uses and Disclosures for Treatment, and Health Care Operations

Lytle EAP Partners may use or disclosure your *Protected Health Information (PHI)*, for *treatment, and health care operations purposes with your consent*. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
 - Treatment is when Lytle EAP Partners provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when Lytle EAP Partners consults with another health care provider, such as your family physician, Drug/Alcohol treatment facility, or another therapist.
 - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our office, such as releasing transferring, or providing access to information about you to other parties.

III. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, and health care operations, we will obtain

an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your EAP notes. "EAP notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your EAP record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or EAP notes) at any time, provided each revocation is in writing. You may not revoke authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

IV. Uses and Disclosures with Neither Consent nor Authorization

Lytle EAP Partners may use or disclose PHI without your consent or authorization in the following circumstances.

- **Child Abuse:** If Lytle EAP Partners has reasonable cause, on the basis of our professional judgment, to suspect abuse of children with whom we come into contact in our professional capacity, we are required by law to report this to your State's Department of Public Welfare.
- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat, we must take reasonable measures to prevent harm. You will be informed in advance if this is the case.

V. Client's Rights and EAP Duties

Client's Rights:

- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example,

- you may not want a family member to know that you are being seen in the EAP. Upon your request, we will contact you at another phone number or address.)
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
 - ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
 - ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section IV of this Notice). On your request, we will discuss with you the details of the accounting process.
 - ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from Lytle EAP Partners upon request, even if you have agreed to receive the notice electronically.

Lytle EAP Partners Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide notice by mail to you.

VI. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Lynn Carrick, EAP Supervisor at 412-357-9547.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VII. Precertification / Managed Care

If the Assistance Program is performing precertification functions, this precertification is for clinical appropriateness only, and does not guarantee that insurance providers will reimburse clients for recommended treatment or therapy. Therefore, it is the ultimate responsibility of the client to assure that the recommended treatment will be reimbursed by the benefit provider (i.e., cases involving pre-existing conditions, exempted conditions, etc.). If you have any additional questions or comments about your experience, feel free to ask any staff member, or call our 24-hour, toll free line.

VIII. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by mail.

Lytle EAP Partners
Acknowledgement of Receipt of Notice of Privacy Practices

Under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to attempt to obtain your written acknowledgement of receipt of the Notice of Privacy Practices.

By signing this form, I acknowledge receipt of the Lytle EAP Partners' Notice of Privacy Practices

Signed: _____

Date: _____

Print Name: _____

Lytle EAP Partners Affiliate Reimbursement Summary

Required;

1. A signed Statement of Understanding
2. A completed Intake Assessment Form
3. A completed Clinical Service Closing Form
4. An Authorization for Disclosure of Protected Health Information Signature Page
5. A signed Consent for Release of Information (only as needed)
6. Acknowledgement of Receipt of Notice of Privacy Practices
7. A Completed Affiliate Invoice

For Compensation Mail Forms To:

Lytle EAP Partners
Attn: Coordinator of Clinical Intake
200 Cedar Ridge Drive, Suite 208
Pittsburgh, PA 15205

-OR-

For Compensation Fax Forms To:

412-921-7261

Affiliate Invoice

Affiliate Name: _____

Affiliate Address: _____

Tax I.D. Number: _____

Client Name: _____

Name of Company for Which Client Works: _____

Date(s) of Assessment	Amount of Time	Rate/Session	Total

<i>Total Amount Due From Lytle EAP Partners</i>	
-------------------------------------------------	--

For Internal Use Only
SS # _____
ID # _____
Date Received _____
CCI Initials _____

To All Affiliate Providers

Lytle EAP Partners' Statement On Self-Referral / Waiver of Referral

This statement is to clarify Lytle EAP Partners' Self-Referral policy and Waiver of Referral policy.

Item 1: When a client has been referred for assessment and referral and/or short term counseling to an EAP/MAP Affiliate Provider, we expect that the Affiliate Provider will see the client for EAP/MAP covered services only. In the event that our clients require long-term counseling, mental health treatment, or intensive therapy, we expect the Affiliate Provider to refer out to other professionals or services covered by the client's health insurance or to services available in the community.

Item 2: EAP/MAP Affiliate Providers are permitted to self-refer under the following circumstances:

- A. No other provider or resource is available in the area and/or.
- B. Treatment considerations are such that to refer out would jeopardize the client's progress or well-being.

Item 3: If the Affiliate Provider believes a self referral is warranted and is able to meet one of the two conditions noted above, the Affiliate Provider needs to:

- A. Contact Lytle EAP Partners and request authorization for self-referral.
- B. Present the client with three (3) provider referrals (unless there are no available providers). The Affiliate Provider may offer his/her name as one of the three. Those referred must be documented on the Waiver of Referral Form.
- C. Have the client review and sign the attached *Waiver Referral Form*.
- D. Send the signed Waiver Referral Form to Lytle EAP Partners along with all other paperwork, (assessments, releases, etc.) and final billing invoicing for EAP/MAP services.

If you have any questions, please feel free to contact Lytle EAP Partners at (412) 921-7000 or 1-800-327-7488.

Lytle EAP Partners
EAP/MAP Waiver of Referral Form

I, _____ (print client name), am requesting to continue counseling beyond my EAP/MAP Benefits with _____(print provider name), a Lytle Affiliate Provider.

At this time, I have either completed the sessions allotted to me under the EAP/MAP benefit or am in need of services beyond the scope of this benefit. My affiliate and I agree that I am in need of further services.

I understand that EAP/MAP clients are usually referred to another provider for continued services. The names of three (3) potential providers were offered to me:

Referral_____	Phone Number_____
Referral_____	Phone Number_____
Referral_____	Phone Number_____

I understand that by signing this waiver, I am declaring that I wish to continue with my current Affiliate and am hereby waiving my right to be referred elsewhere for services. I understand that I am releasing the EAP/MAP and Lytle EAP Partners from providing any further services.

I further understand that I am personally responsible for payment of additional services and that I may pursue partial reimbursement through my health insurance benefit plan.

Client's Signature

Date

Affiliate Provider

Date