Beacon On-Site EAP Case Activity Form

(Use only if EAP services delivered by Beacon On-Site EAP)

Instructions: Please use CAPITAL letters and complete ALL information. This form is for on-site case activity documentation. Use CAF-1 form for billing of pre-authorized services delivered off-site. Submit ONLY via secure ZIX email to DCU@beaconhealthoptions.com

Status Type: ☐ Interim ☐ Final ☐ Re-Open

Statement of Understanding Signed: ☐ Yes ☐ No

Release of Information Signed: ☐ Yes ☐ No

Payer: *(corporate client, employer, company/division, location or department through which EAP benefits are available)*

Participant Information: *Last Name* *First Name* *MI*

Participant's Address: *Street Address* *City*

State *ZIP Code* **Date of Birth** (mm/dd/yy) **Participant Home Phone**

Participant Relationship to Employee:
☐ Self ☐ Spouse ☐ Dependent ☐ Parent
☐ Sibling ☐ Unmarried Partner ☐ Other

Participant Ethnicity:
☐ African-American ☐ Arab-American ☐ Asian / Pacific Islander
☐ Caucasian ☐ Hispanic ☐ Multi-Racial ☐ Native American ☐ Other

Relationship Status:
☐ Never Married ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Cohabitating

Referral Source:
☐ Self ☐ Union ☐ Co-worker ☐ Medical ☐ HR ☐ Supervisor (Informal)
☐ Wellness Program ☐ Treatment Provider ☐ Supervisor (Job Performance)

Learned About EAP:
☐ Word of Mouth ☐ Printed Materials ☐ Company Representative
☐ Electronic Media ☐ Training / Health Fair ☐ Union Representative

● **Method of Initial Contact:** On-Site EAP

Participant Gender: ☐ Female ☐ Male

Employee SSN (if available)**:** **Employee Hire Date** (mm/dd/yy)

Employee Name: *(if not participant)* *Last Name* *First Name* *MI*

Employment Data: *(complete only if employee is participant)*

Employment Status:
☐ Full Time ☐ Part Time ☐ Terminated ☐ Medical Leave ☐ Retired
☐ Disciplinary Leave ☐ Laid Off ☐ Disability / WC Leave ☐ Other

Job Dysfunction:
☐ None ☐ Minimal ☐ Significant: No Job Jeopardy
☐ Moderate ☐ Significant: Job Jeopardy

Job Problem:
☐ Absenteeism ☐ Fitness for Duty ☐ Safety Issue(s) ☐ Unpaid Leave ☐ Tardiness ☐ Positive Drug Screen ☐ None
☐ Productivity Issue(s) ☐ Co-worker Relationship ☐ Supervisor Relationship ☐ Aberrant Behavior ☐ Work Performance

Job Title Category:
☐ Executive / Manager ☐ Professional ☐ Sales ☐ Office / Clerical ☐ Service Worker
☐ Technical ☐ Craft Worker (skilled) ☐ Operative (semi-skilled) ☐ Laborer (unskilled)

Union Member: ☐ Yes ☐ No

Session Information: Date(s) of Service (mm/dd/yy)

EAP Clinician: *Last Name* *First Name* *MI*

Clinician's Mailing Address: *Street Address* *City*

State *ZIP Code* **SSN or Tax ID Number:** **NPI Number:**

Participant Last Name | *First Name* | Date of Birth (mm/dd/yy)

Clinician Phone: ___-___-____ **EAP Clinician Signature**: _____ **Date**: _____

Total Sessions Completed: ____ **Clinician Email**: _____

Number of EAP Sessions Used at Case Closing: ____

Presenting and Assessed Problem: *choose only one Presenting problem (P) and one Assessed problem (A)*

P	A		P	A		P	A		P	A	
☐	☐	Alcohol	☐	☐	Eating Disorder	☐	☐	Child Care	☐	☐	Job / Occupational
☐	☐	Drugs	☐	☐	Hyperactivity/Learning	☐	☐	Adult / Elder Care	☐	☐	Legal
☐	☐	Mixed Alcohol / Drug Abuse	☐	☐	Impulse control	☐	☐	Family Problem	☐	☐	Marital / Relationship
☐	☐	Anxiety	☐	☐	Thought disorder	☐	☐	Financial Problem	☐	☐	Situational / Adjustment
☐	☐	Depression				☐	☐	Grief / Loss	☐	☐	Medical Problem

Risk and Functional Assessment: Indicate participant's level of impairment at case opening and at case closing.

0 = No evidence of impairment; 1 = mild; 2 = moderate; 3 = severe impairment

	Case Opening	Case Closing
Member's risk to self……	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Member's risk to others…….....	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Mood Disturbances (depression or mania)……..	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Anxiety……	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Thinking / Cognition / Memory / Concentration….....	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Impulse / Reckless / Aggressive Behavior…….....	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Activities of Daily Living Problems…….	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Medical / Physical Condition……..	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Substance Abuse / Dependence…….....	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Job / School Performance……..	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
Social Functioning / Relationship / Marital / Family…	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3

Goals:

1.	☐ Met ☐ Partially Met ☐ Not Met ☐ No Change
2.	☐ Met ☐ Partially Met ☐ Not Met ☐ No Change
3.	☐ Met ☐ Partially Met ☐ Not Met ☐ No Change

EAP / Psychiatric History Assessed ☐ Yes ☐ No Notes: _____

Substance Abuse Treatment History Assessed ☐ Yes ☐ No Notes: _____

Strength, Skills, Aptitude and Interests Assessed ☐ Yes ☐ No Notes: _____

Supports Assessed ☐ Yes ☐ No Notes: _____

Military History Assessed ☐ Yes ☐ No Notes: _____

Case Closing

Problem Status at Closing:
- ☐ Resolved
- ☐ Partially Resolved
- ☐ Getting Worse
- ☐ No Change
- ☐ Not Applicable

Case Disposition:
- ☐ Face-to-face assessment / no referral
- ☐ Face-to-face assessment / referral accepted
- ☐ Face-to-face Assessment / referral declined
- ☐ Did not keep initial appointment
- ☐ Withdrew before completion of services

Referral Type:
- ☐ No referral beyond EAP
- ☐ Community Resource
- ☐ Medical Treatment

Substance Abuse Treatment
- ☐ Inpatient
- ☐ Intensive Outpatient
- ☐ Detox Only
- ☐ Other

Psychiatric Treatment
- ☐ Inpatient
- ☐ Partial Hospitalization
- ☐ Outpatient (non-MD)
- ☐ Outpatient (MD)
- ☐ Other