Federal Occupational Health (FOH)
Employee Assistance Program

FOH Documents

Frequently Asked Questions
Statement of Understanding
Authorization to Use or Disclose Confidential Information
Consent to Presence of Translator/Interpreter
Consent to Treatment (Minor)
Member/Client Experience Survey QR Code
Record Inquiry/Request

Introduction

Federal Occupational Health (FOH), an agency within the Department of Health and Human Services (HHS) and Program Support Center (PSC), contracts with Magellan to provide an EAP to civilian employees for a consortium of government agencies such as the Department of Health and Human Services, the Department of Transportation, and US Department of Agriculture. Clients may not be aware that their EAP is part of FOH or Magellan.

This appendix provides important account-specific information about the FOH EAP. For complete policies and procedures for Magellan EAP providers, please reference the other sections of this handbook supplement. Direct questions about the FOH EAP or the contents of this section of this appendix to Magellan's FOH EAP staff at **1-800-222-0364**

Dos and Don'ts

- You are not to grant interviews or provide any information to any form of media regarding individual clients, FOH customer agencies, or Magellan (or FOH) policies or procedures.
- You are not to provide any written or verbal communications to FOH customer agencies or their management or other officials for any reason including fitness-for-duty or requests for job changes or time off. Federal agencies require physician documentation regarding fitness-for-duty, time off, etc.
- You are not to contact or respond to FOH customer agency personnel regarding a client.
- You MAY provide a note confirming session attendance, including date and time, if the client makes this request. Notes confirming attendance should be written directly to the client, not to the agency or supervisor.

Dual-Client Relationship

Within the consortium of FOH customer agencies, there are civilian employees, unions, and many layers of management; it is key that the EAP, including EAP providers serving the program, maintain neutrality and confidentiality for both the client and the customer organization in all aspects of service delivery. You are not to contact a client's supervisor, union representative or any other agency personnel directly.

FOH EAP Components

Self Referrals
Employees of covered federal agencies and their household members may access the FOH EAP by calling the FOH EAP toll-free number at 1-800-222-0364 (for deaf or hard of hearing members, call 711) to request services.

Management Referrals
Supervisors may formally or informally refer employees who demonstrate job performance, attendance, and/or other conduct problems to the EAP.

An informal management referral occurs when a manager recommends the EAP or reminds an employee about the EAP upon disclosure of a personal issue by the employee to the manager.

A formal management referral occurs when, after consulting with Magellan, a manager provides an employee with a referral to the EAP as a resource to assist with an ongoing job performance issue or conduct issue. You, the EAP provider, are expected to meet with the employee to both assess the supervisor's concerns and evaluate the employee's perception of the problem(s) identified by the supervisor and any other problems that the client may identify.

At no time should you be in direct contact with the employee's agency personnel regarding the employee. All contact with the employee's agency MUST be from Magellan.

Critical Incident Response (CIR)
EAP providers may be asked to provide in-person individual and/or group support to persons who have experienced threats or actual violence, either in the workplace or at another location; threats or actual acts of suicide or homicide; events that severely impact the worksite, such as a natural or man-made disaster, death, severe injury or traumatic experience by members of a work group; or any other situation that might have psychological, legal and/or media impact on a customer agency.

If Magellan requests you to conduct a CIR service, fee arrangements will be made at that time by a Magellan representative. A Magellan FOH staff member will consult with you regarding the response prior to your going onsite. When responding to a Federal building or site, please bring photo ID and allow extra time for security screenings.

Administrative Procedures

Appointment Procedures

FOH clients access their EAP by calling 1-800-222-0364.

- Each call is answered live by a triage counselor at Magellan's Service Center.
- The triage counselor obtains demographic data and assigns a referral MAT number.
- The triage counselor facilitates a referral to a Magellan EAP provider.
- Magellan's Service Center staff will assist the client in contacting the assigned EAP provider to arrange an appointment.
- Appointments must be offered for times that are convenient to employees and/or their household members. Clients with urgent situations (cases involving risk of harm, abuse, or other circumstances in which a client is at serious risk to deteriorate without timely intervention) must be offered an appointment within 24 hours; clients with non-urgent (routine) cases must be offered an appointment within 5 days. If you are unable to provide appointments to meet these time frames, contact the Magellan Service Center at 1-800-222-0364.
- FOH EAP clients may not be required to provide a Social Security Number to access EAP services.

Documentation

Beginning with the first client contact, you are to maintain a record of contacts with and/or relating to each client, with the most recent information at the front of the record. Notes are to contain identifying information only as reasonably needed for your services. You are responsible for ensuring that every client record is legible, orderly, accurate, and complete. Every action you take must be documented, as well as on-going progress notes; each note must contain your signature.

Upon each case assignment, you will receive access to an electronic EAP registration packet that includes:

- EAP Referral Sheet with case-specific information (e.g., client name, number of sessions, presenting problem).
- EAP provider letter explaining the FOH EAP.
- Statement of Client Understanding (SOU) that ***each*** client is required to sign prior to receiving EAP services. The **FOH EAP SOU is specific for the account; use the FOH SOU for all FOH cases** (included in this appendix). *Note:* every adult present in EAP sessions must sign an SOU. Depending on your state law, the SOU for a minor client must be signed by the minor and/or his or her parent or other legal guardian. If state law requires that one or both parents or legal guardian consent to treatment, then that person or persons must also sign the SOU. If the minor is permitted to consent to treatment on his or her own, only the minor need sign the SOU. Review the SOU with the client to assure his/her understanding of EAP services and limits of confidentiality. If the client has a question that you cannot answer, refer the client to the Magellan Service Center (1-800-222-0364).
- Consent to Treatment for a Minor form that a parent with legal custody or a legal guardian signs if the client is a mino*r who* is not able to consent to treatment on his or her own under applicable state law.
- Consent for release of confidential information (see Authorization to Use or Disclose Confidential Information and Record Inquiry/Request forms included in this appendix) that the client is required to sign only if records/information are to be released.
- Client Satisfaction Survey QR code—request that the client scan the code and complete the 5-question survey.

Payment Procedures

At no time, under any circumstance, may a client or a client's health benefit plan—or anyone other than Magellan—be billed for services rendered under the FOH EAP.

- To receive payment for EAP sessions rendered, you must submit the EASI Form to Magellan. The EASI Form must be *received* by Magellan within 90 days of the EAP referral end date indicated on the Magellan referral sheet.
- You may submit for payment for FOH EAP cases via the online EASI Form at MagellanProvider.com (requires sign in).
- Billing on CMS forms, Magellan's Treatment Request Forms, or any other forms **will not** be accepted.
- Magellan will arrange and pay for any interpreter services that are needed for clients with special language needs. Interpreters/translators will submit their invoices directly to Magellan.
- Billing and payment issues are not to be discussed with clients. Questions about billing or payment should be directed to Magellan.

In accordance with Magellan's policy, you will not be paid for FOH EAP clients who do not show for or who cancel their appointments. If your office has a policy regarding no-show or cancelled appointments, we recommend that you provide a copy of the policy to the client no later than the first session. If the client fails to show up for or cancels an appointment after the first session, you may bill the client directly for the cancellation fee in accordance with the policy you have provided the client.

Service Delivery

Number of Sessions Available

- This program is based on the needs of the client within the framework of a brief, short-term EAP counseling model. There are a variety of session models available for agencies to choose for their employees – 1 to 3 and 1 to 6 session models are the most common. The EAP referral sheet will indicate the total number of sessions in the session model selected by the customer agency through which your client is eligible for EAP services.
- If your initial assessment suggests that care beyond the EAP sessions is needed or if at any time during the short-term counseling process a need for longer care is indicated, a referral should be facilitated to the client's health benefit plan or other community resource as soon as it is clinically appropriate.
- You may make referrals, as necessary, to appropriate resources within the community. You are required to discuss a range of referral options, including self-help groups and/or professional resources eligible under the client's health benefit plan.
- Under FOH guidelines, you may offer yourself as a referral source for longer-term counseling.

Services Not Available Under the FOH EAP

If the client requests these or similar services that are outside the scope of the EAP, refer the client back to the program at 1-800-222-0364 for additional resources:

- Court-ordered therapy
- Custody evaluations
- Fitness-for-duty evaluations
- Evaluations for workers' compensation claims, disability claims or other legal proceedings
- Psychological testing
- Group therapy
- Outplacement job search
- Financial counseling for investments
- Learning disability testing
- Drug testing
- Legal advice
- Services outside the established counseling office.

Subpoenas or Requests for Clinical Records

- You may receive a subpoena in connection with an EAP case. A subpoena should not be confused with a court order. A subpoena is a legal document that is generally issued by an attorney or court clerk. A valid court order from a court of competent jurisdiction is signed by a judge. Please refer to your own legal counsel for guidance when in receipt of a subpoena or court order or contact the Magellan Service Center. Magellan does NOT provide legal advice about how you should respond to a subpoena or court order you receive.
- If a client or any other party requests a client's records, please have the requester complete the Record Inquiry/Request form and the Authorization to Use or Disclose Confidential Information form (included in this appendix). See Summary of Privacy Act Requirements for details on legal requirements for responding to requests for records.
  - You, the EAP provider, must obtain appropriate means of identification to verify the identity of the requester.
  - When the client requests the record, the client must name a designated representative to receive the record. If you think that access to any part of the record could be harmful if given directly to the client, please refer to your own legal counsel for guidance, or contact the Magellan Service Center.
  - If you have any questions regarding this process, contact 1-800-222-0364.

Delivering Services to Clients with Disabilities

- **Visually impaired clients:** You should read aloud all forms that are presented to clients for examination and/or signature (e.g., Statement of Client Understanding, Authorization to Use or Disclose Confidential Information). You should document the reading in the client's case record, including the client's response to the reading.
- **Deaf or hard of hearing clients or clients with special language needs:** If an interpreter/ translator is required for a deaf or hard of hearing client or a client who has special language needs, Magellan Service the Center will locate an interpreter/translator and coordinate services between you and the interpreter. When an interpreter is utilized, you are to obtain the client's signature on a "Consent to Presence of Translator/Interpreter" form (included in this appendix).
- **Physically impaired clients:** Your office, restrooms and parking facilities must be fully accessible to persons with physical disabilities. When your office cannot accommodate a physically disabled client, you are to arrange for an alternative accessible location in which the client can receive services.

Federal Occupational Health (FOH)

EAP Documents

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Federal Occupational Health (FOH) EAP

Frequently Asked Questions

What is required of the member at the first session?
During the first session, you must have the FOH member sign the *Statement of Understanding*.

What should the initial assessment entail?
Conduct a thorough assessment of the member, including assessment for risk and substance use. If the initial screening suggests alcohol or drug use, complete the full assessment.

What should the initial assessment exclude?
Do **not** conduct fitness-for-duty or return-to-work assessments. Also, do **not** approve leaves of absence or suggest that the EAP can change the employee's work responsibilities.

What's next after the assessment?
Offer short-term problem resolution services if appropriate, or refer the member for longer-term care under their insurance plan.

Can I release session information to the member's employer?
No, do not release verbal or written information to the employer. This is prohibited by your EAP affiliate contract.

Do I need to staff cases that aren't routine in nature?
No.

With whom should I consult if I have questions about billing?
If you have questions about billing, contact the FOH EAP at 1-800-274-2477. Do NOT bill or discuss billing concerns with the member, their employer or their insurance company.

How do I request reimbursement for services?
Complete and submit the *Employee Assistance Services Information (EASI) Form*. Be sure to document alcohol or drug use as a primary or secondary problem, even if the member is in denial or does not wish to address the issue; this information is NOT released to the employer. Submit the EASI Form within 90 days of the case's registration end date (due to contractual guidelines, late submissions will not be paid). You can submit the EASI Form online or by mail or fax. See EAP reimbursement contact information. *(Press CTRL + click to link in a new browser.)*

FEDERAL OCCUPATIONAL HEALTH
EMPLOYEE ASSISTANCE PROGRAM

STATEMENT OF UNDERSTANDING

Welcome to the Federal Occupational Health (FOH) Employee Assistance Program (EAP). This document provides an overview of the confidentiality parameters of the FOH EAP program. The FOH EAP provides consultation, short-term counseling, and resources to assist with personal or professional concerns that impact productivity and well-being. FOH EAP services are available, at no cost, to eligible federal employees and their immediate family members. The FOH EAP also offers consultations to supervisors to assist them in their efforts to help employees.

The FOH EAP is non-medical in nature and therefore does not formally diagnose or treat health issues. FOH EAP Consultants are licensed behavioral health professionals who work with you to assess a situation, explore problem-solving alternatives, and develop a plan to implement such options. Consultation with the FOH EAP may involve the exploration of painful personal material. The consultation plan may include short-term EAP counseling and/or coaching services, as well as referrals to community resources. Please be advised that your agency and FOH and FOH EAP contractors are not responsible for the treatment costs and/or services for which you may be referred beyond the FOH EAP
counselor and it is your sole responsibility to pay for all such services including all charges not covered by insurance plans.

Participation in the FOH EAP is voluntary. Employees may be referred to the EAP by supervisors for work performance and/or conduct issues. Information about an employee's visit to the EAP will not be released to a supervisor without the employee's written consent, regardless of the nature of the referral.

CONFIDENTIALITY
The FOH EAP is a confidential service. Information disclosed to the FOH EAP will only be communicated outside the EAP under the following circumstances: 1) you consent in writing; 2) life or safety is seriously threatened; 3) disclosure is required by law; 4) there is suspicion of abuse or neglect of a child or another vulnerable person. The authorities for the FOH EAP and for the maintenance of your record are detailed in 5 U.S.C. 552a, 7361, 7362, 7901, 7904, and 44 U.S.C. 3101.

Upon request, the FOH EAP can provide program attendance confirmation which EAP clients may distribute to a direct supervisor or other organizational representative at their discretion. Please be advised that any communication through email or by any phone other than a land line is not secured communication. If such communication is initiated by you, then consent to communicate over an unsecured network is implied. If this is not your desire please inform your counselor.

I have read and acknowledge the above Statement of Understanding:

Client Name (print) _____

Client Signature _____ Date: _____

EAP Counselor Name (print) _____

EAP Counselor Signature _____ Date: _____

If you have questions about this form, please call (800) 222-0364

FOH4You.com

U.S. Department of Health and Human Services
Federal Occupational Health
Employee Assistance Program

Authorization to Use or Disclose Personally Identifiable Information

Section 1. Whose information will be disclosed?

Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YYYY) / /

Street Address	City	State	Zip Code	Phone Number

I hereby authorize the use or disclosure of confidential information about the individual named above. I am:

- ☐ the individual named above (complete Section 8 below to sign this form)
- ☐ a personal representative because the client is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who will disclose information about the individual?

The following person(s) or entity may use or disclose the information:

Name (a person, a class of persons like "counselor who saw me in August 2007," or an organization)	Phone Number (if known)

Street Address (if known)	City, State and Zip Code (if known)

Section 3. Who will receive information about the individual?

The information may be disclosed to:

Name (a person, a class of persons like "family members residing with me", or an organization)	Phone Number (if known)

Street Address (if known)	City, State and Zip Code (if known)

Section 4. What information about the individual will be disclosed?

Only the following information (*Client must **INITIAL** each item to be disclosed*)

- ☐ Whether I am participating in the EAP
- ☐ Attendance records
- ☐ Progress report on my EAP counseling
- ☐ Prognosis
- ☐ Drug/alcohol history
- ☐ Results of mental status examination
- ☐ Other (describe information to be disclosed & any restrictions): _____
- ☐ Whether I am complying with EAP recommendations
- ☐ Closing summary
- ☐ EAP recommendations
- ☐ EAP intervention summary
- ☐ Diagnosis/assessment

Section 5. What is the purpose of the disclosure?

- ❑ To verify whether I am participating in and complying with EAP recommendations **(Formal referral)**
- ❑ To enable the EAP to make a referral for treatment
- ❑ To enable the EAP to verify my attendance at an EAP session on-the-clock
- ❑ At my request
- ❑ Other (*please describe*): _____

Section 6. What is the expiration date*?*

This authorization must expire in two years.

❑ **Date two years from today:** _____/_____/_____

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing FOH EAP, MO-22 P.O. Box 2124, Maryland Heights MO 63043. If you revoke this authorization, the revocation will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to FOH EAP, MO-22 P.O. Box 2124, Maryland Heights MO 63043.
- If you have any questions about anything on this form, or how to fill it out, we can help. Please call 1-800-222-0364.

Section 8. Signature of the Individual

I am the individual I claim to be and I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense under the Privacy Act, subject to a $5000 fine.

Signature_____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature_____ Date (required) _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare. You may be asked to provide us with the relevant legal document giving you this authority. Relationship to the individual (required): __

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which is protected by federal and may also be protected by state law. If the records relate to alcohol and drug abuse patient records, you are prohibited by 42 CFR Part 2 from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person named above, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CONSENT TO PRESENCE OF TRANSLATOR/INTERPRETER

I, _____, wish to receive assessment and/or brief counseling services through the Federal Occupational Health Employee Assistance Program (FOH EAP).

❑ I am deaf/hard of hearing, and/or
❑ The language I speak is _____

I wish a translator/interpreter who communicates in _____ to be present during counseling sessions with my counselor so that I may communicate effectively with my counselor.

Translator/interpreter I want:

❑ Member of my family ❑Other

Name: _____

Relationship: _____

Telephone Number: _____

❑ Translator/interpreter selected by FOH EAP

I understand that by electing to have a translator/interpreter present, the translator/interpreter will be privy to all information that I share with my counselor.

I understand that I may revoke my consent to the presence of the translator/interpreter at any time except to the extent that action has been taken in reliance upon it. However, I acknowledge that such revocation may comprise the quality of subsequent counseling.

Date: _____ _____
Signature

Date: _____ _____
Witness

Acknowledgement of Confidentiality Obligations by Translator/Interpreter

I, _____, agree to serve as a translator/interpreter during counseling sessions for the above client. I understand that any and all information relating to the counseling, including the identity of the client, is confidential information and that federal and state law prohibits me from re-disclosing the information without written authorization of the client.

Date: _____ _____
Signature

Federal Occupational Health (FOH)
Employee Assistance Program (EAP)

CONSENT TO TREATMENT (MINOR)

Name of minor: _____

Age: _____years, birth date: _____

I, _____, am the legal custodian of the above-named minor.
Please print

Please check one:

- ❑ I have full legal authority to consent to treatment of the minor without obtaining consent or approval of another person.
- ❑ I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person.

I hereby authorize the FOH EAP to provide counseling to the minor in connection with substance abuse, mental health and/or other personal problems.

_____
Parent or Legal Guardian

Date: _____

Witness: _____

Member/Client Experience Survey QR Code

Share this flyer with the client at the last session or mail it to them at case closure (also included in the referral packet).

THANK YOU

Behavioral Health Services
Employee Assistance and WorkLife Programs

24 HOURS A DAY

800-222-0364

TTY: 888-262-7848

foh4you.com

Scan to let us know how we did! We value your feedback.

PSC | Federal Occupational Health

Behavioral Health Services
Employee Assistance Program

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RECORD INQUIRY/REQUEST FORM

REQUESTED BY:

Name: _____

Address: _____

Home/Cell phone:_____

Work phone:_____

CLIENT INFORMATION:

Client name (if different from above): _____

Client address (if different from above): _____

Client date of birth: ____/____/_____

Is client a minor? Yes* ❑ No ❑

Client phone (if different from above):_____

EAP INFORMATION

Approximate dates of EAP use: ____/____/_____

❑ Records relating to calling to the EAP number

❑ In-person counselor Name of counselor:_____

Location of counseling (address if known, city, state):_____

INFORMATION ABOUT REQUEST

Need for disclosure: _____

Designated representative to review record (health professional or another responsible person; this can be the EAP counselor if that is client's choice. For minors, it must be a health professional):

_____

Designated representative's address (address if known, city, state):

_____

SIGNATURE OF REQUESTOR:

I certify that I am the person identified above. I understand that knowingly and willfully requesting and obtaining a record about an individual under false pretenses is a criminal offense subject to a $5,000 fine.

Signature: _____

Date: ____/____/_____

Send completed form to: MFGetEthics@MagellanFederal.com

*Federal regulations protect the privacy of minors. Parents and legal guardians may not be given direct access to their records by the EAP. Instead, records requested by parents and legal guardians are sent to a designated health professional.

The original version of this material was developed by Magellan Behavioral Health for the Department of Health and Human Services through contract number HHSP23320075300DC with Federal Occupational Health Services. July 2023