NEBRASKA LICENSEE ASSISTANCE PROGRAM

A SERVICE OF BEST CARE EAP

Appt_____

File Number _____

Name _____
First *Middle* *Last*

Address _____

City _____ State _____ Zip _____

MAY WE SEND A FOLLOW-UP LETTER OR QUESTIONNAIRE TO YOUR HOME ADDRESS? YES NO

Home Phone _____ Cell Phone _____ Work Phone _____

May we call?	Home	Y	N	Cell	Y	N	Work	Y N
Leave message?	Home	Y	N	Cell	Y	N	Work	Y N

Best time to be reached by phone _____

Gender _____ Age _____ Date of Birth _____ Last 4 Digits of SS #_____

IN CASE OF EMERGENCY, PLEASE CONTACT _____PHONE _____

Spouse/Significant Other _____ Age _____

Date Married/Length of Relationship _____ Any prior marriages Y N

	Name	Age	Relationship
Children and/or any other household members	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Insurance Company _____

INFORMATION ON THE INDIVIDUAL UTILIZING NE LAP SERVICES

Profession _____ License _____

Additional License(s) _____

Employer/Agency _____

Department/Division _____ Scheduled Work Hours _____am/pm to _____ am/pm

Of Hours Per week _____

Position/Job Title _____

Were you referred by an individual, group or agency to the NE LAP? _____ Yes _____ No

If yes, please explain why _____

If no, how did you learn about NE LAP? _____

Please briefly describe any personal issues you would like to address through your NE LAP services.

_____

_____

What are your specific goals for your involvement with the NE LAP?

1. _____
2. _____
3. _____

Have these issues been addressed in any prior counseling or treatment? _____ Yes _____ No
If yes, please explain _____
_____

Are you utilizing any other counseling or treatment services at this time? ____ Yes ____ No
If yes, please list the provider

Counselor/Therapist _____ Minister _____
Treatment Program _____ Psychologist _____
Primary Physician _____ Psychiatrist _____

Are you using any medications at this time? _____ Yes _____ No
If yes, please list all the medications

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Would you like us to, or do we need to, discuss your issues with someone else? _____ Yes _____ No
If yes, please list the individuals below. We will help you complete the Authorization to Disclose Information forms that allows us to do this.

1. _____ Phone # _____
2. _____ Phone # _____
3. _____ Phone # _____

Are your alcohol/drug issues causing you worry, fears or possible anxiety? _____ Yes _____ No
If yes, please circle your answers to the following *Generalized Anxiety Disorder (GAD-7)* questions.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T _____ = _____ + _____ + _____)

Are your alcohol/drug issues causing you discouragement, sadness or possible depression? ___ Yes ___ No
If yes, please circle your answers to the following *Patient Health Questionnaire (PHQ-9)* questions.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - - being so fidgety or restless that you have been moving around a lot more that usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(For office coding: __0__ + _____ + _____ + _____= Total Score: _____)

If you circled <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Do your alcohol/drug issues involve gambling? _____ Yes _____ No
If yes, please check your answers to the following *Gambling Screening* questions.

1. In the past 12 months have you gambled more than you intended to?
   _____No _____ Once Only _____More Than Once

2. In the past 12 months have you claimed to be winning money when you were not?
   _____No _____Yes

3. In the past 12 months have you felt guilty about the way you gamble or about what happens when you gamble?
   _____No _____Yes

4. In the past 12 months have people criticized your gambling?
   _____No _____Yes

5. In the past 12 months have you had money arguments that centered on gambling?
   _____No _____Once Only _____More Than Once

6. In the past 12 months when you were gambling, did you feel that you had to persist until you won?
   _____No _____Yes

7. If you answered yes to 2 or more of these questions, how often has it happened?
   _____No _____Once Only _____More Than Once

(For office coding:
Yes to one _____
Yes to two or more but Once Only_____
Yes to two or more or More Than Once or more than three _____)

BEST CARE EMPLOYEE ASSISTANCE PROGRAMS
NOTICE OF PRIVACY PRACTICES

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

This Notice applies to the following programs or services that are affiliated as part of Methodist Health System, Best Care Employee Assistance Program (Best Care EAP), and share similar information practices:

►Methodist Health System ● (402) 354-6863
►Best Care Employee Assistance Program ● (402) 354-8000 / (800) 801-4182

►Substance Abuse Expert Services ● (402) 354-8000 / (800) 801-4182

►Nebraska Licensee Assistance Program ● (402) 354-8055 / (800) 851-2336

►Community Counseling Program ● (402) 354-6891

Privacy Contact (402) 354-8096

The programs and services listed above will share your clinical information with each other, as necessary, to carry out counseling, payment and clinical services operations.

Understanding Your Record/Clinical Information
Every time you visit a Best Care Employee Assistance Program clinical service, a record of your visit is made. This record may include your presenting problems, background information, assessments, treatment, and plans for future clinical services. This information - your client record – is used to plan your clinical services.

Your Rights
Although your client record belongs to the program or service that compiled it, you do have certain rights with regard to your clinical information.

- You have the right to expect that your clinical information will be kept secure and used only for legitimate purposes.
- You have the right to receive this privacy notice that tells you how your clinical information may be used or disclosed.
- You have the right to know who has seen your clinical information during the previous six years, and for what purpose. If you make additional requests for such an accounting during any 12-month period, we may charge you a reasonable, cost-based fee.
- You have the right to view, and receive a copy or summary of, all of your clinical records in the format you request (electronic and/or paper), except for psychotherapy notes. Your request for a copy of your record must be in writing. We may charge you a reasonable, cost-based copying or labor fee for such copy.
- You have the right to ask for correction or amendment of anything in your records that you feel is in error. If we are unable to comply with your request we will notify you why in writing within 60 days. You also have the right to request that a statement of disagreement be included in your record. Your request must be in writing and include supporting documentation.
- You have the right to request we not use or share certain clinical information you consider especially sensitive for counseling, payment or our clinical services operations. You also have a right to request we not share information with your health insurer if you pay for a service or item out-of-pocket in full. However, we are not required to accommodate your request except as provided below.
- You have the right to be notified of a breach of your unsecured protected clinical information.
- You have the right to request confidential communications by asking us to contact you in a specific way or to send mail to a different address. We will honor all reasonable requests.
- You have the right to choose someone to act for you. If you give someone medical power of attorney or if someone is your legal guardian, we will confirm the person has the authority and can act for you before we take any action.

Your Choices
You have the right and choice to tell us to:

- Share information with your family, friends or others involved in your care;
- Share information in a disaster relief situation;
- Contact you for fundraising efforts.

Our Responsibilities
We also have certain responsibilities. These include:

- Maintaining the privacy and security of your clinical record;
- Providing you with a copy of this Notice;
- Abiding by the terms of this Notice;
- Notifying you if a breach occurs that may compromise your information;
- Not using or sharing your information other than as described in this Notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time; let us know in writing if you change your mind.

We may revise this Notice as our information practices change. Any revision will be effective for all information in the record, regardless of whether it was gathered before or after the change took effect. However, before we change our practices, a copy of our new Notice will be posted at all Best Care EAP offices and on our web site. The effective date of our Notice will always appear at the end of the Notice.

Our Uses & Disclosures for Clinical Services, Payment and Program Operations
When state law requires us to obtain your written permission to use or disclose your information for your clinical services, payment or program operations, we will do so. However, there are also situations where we may use or disclose your information for clinical services, payment and program operations without your permission.

We may use or disclose your information for clinical purposes.

For example: Information obtained by members of your clinical team will be documented in your record and used to determine the course of your clinical care. Your clinician, his/her clinical supervisor, and Best Care EAP management may communicate with one another personally and through your client record to coordinate your care. These exchanges may be done through electronic information networks.

We may use or disclose your information for payment purposes.

For example: We may provide your physician or other service provider with copies of reports that may help determine your future treatment. We may also disclose your information to another service provider for its payment purposes or its health care operations. We may send your bill to you or your insurance company. Your bill may contain information that identifies you, as well as your diagnosis, procedures and supplies used. However, if you pay for a clinical service out-of-pocket in full and request in writing that we not provide information to your health insurer, we will comply with your request unless a law requires us to share that information with them.

We may use or disclose your clinical information for program operations purposes and internal business practices.

This information is used in our ongoing efforts to improve the quality and effectiveness of the clinical services we provide.

Other Disclosures That May be Made Without Your Authorization
Unless we are otherwise restricted from doing so, we may also use or disclose your information for the following purposes without your authorization:

Affiliate Providers: Some services of our program are provided through contractual arrangements with affiliate providers. These include assessments, counseling, training, consultation, coaching, and other related services. When services are provided by an affiliate, we may exchange your information with each other so that we can provide the services that we have been asked to provide and they can bill us for those services. Our affiliate providers must use appropriate safeguards to protect your clinical information.

Business Associates: Some services of our organization are provided through contractual arrangements with business associates. When services are provided by a business associate, we may disclose your clinical information to our business associate so that they can perform the job we have asked them to do. In addition, we may disclose your clinical information to accrediting agencies and certain outside consultants. Our business associates must use appropriate safeguards to protect your clinical information.

Public Health: When required or permitted by law, we may disclose your clinical information to public health or legal authorities responsible for preventing or controlling disease, injury, or disability or performing other public health functions. In addition, we may disclose your clinical information in order to avert a serious threat to health or safety.

Specialized governmental functions: We may disclose your clinical information for military and veterans activities, national security and intelligence activities, and similar special governmental functions as required or permitted by law.

Law enforcement: We may disclose your clinical information for law enforcement purposes as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

Disclosures required by law: We may use or disclose your clinical information as required by law provided such use or disclosure complies with and is limited to the relevant requirements of such law.

Health Oversight Agencies: We may disclose your health information to an appropriate health oversight agency, public health authority or attorney involved in health oversight activities.

Judicial and Administrative Proceedings: We may disclose your clinical information for judicial or administrative proceedings as required or permitted by law or in response to a valid subpoena, court order or other binding authority.

For More Information or to Report a Problem
If you have questions or would like additional information, you may contact Best Care EAP's Privacy Contact at the phone number listed at the beginning of this Notice or the Methodist Health System (MHS) Privacy Officer at (402) 354-6863. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Contact, with the MHS Privacy Officer, or with the Office of Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Effective Date: October 1, 2016

File# _____

BEST CARE EMPLOYEE ASSISTANCE PROGRAMS
(Nebraska Licensee Assistance Program)

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

☐ I have received the Best Care Employee Assistance Programs (Nebraska Licensee Assistance Program) Notice of Privacy Practices. (Note: My signature does not indicate that I have read, understood or agree with the Notice, only that it has been provided to me.)

_____ _____
Signature of Client Date

For Best Care Employee Assistance Programs use only

Documentation of Good Faith Effort

☐ Attempted to distribute the Notice of Privacy Practices to the client, but the client declined to acknowledge the receipt of the Notice of Privacy Practices.

☐ Client directed to Best Care EAP website to view the Notice of Privacy Practices.

☐ The Notice of Privacy Practices was mailed to the client on _____.
(Date)

☐ Other _____

_____

_____

_____ _____
NE LAP Coordinator/Counselor Date

NEBRASKA LICENSEE ASSISTANCE PROGRAM

Notice to Nebraska Licensee Assistance Program Clients: Public Health and Safety and Treatment Compliance

Pursuant to Nebraska law, (Nebraska Revised Statute 38-175), the contract between the Nebraska Department of Health and Human Services and Best Care Employee Assistance Program requires the Nebraska Licensee Assistance Program (NE LAP), with respect to all licensees, certificate holders, and registrants (credential holders) who access the NE LAP, to report the credential holder to the Department of Health and Human Services, Division of Public Health, (the Division) when the program makes a determination that:

1. Continued practice would pose a danger to the public health and safety; or

2. The credential holder fails to comply with any term or condition of the NE LAP treatment plan.

If such a determination is made, the NE LAP reports this determination as required by this Nebraska law to the Division first by telephone and then by letter.

At this time of your admission into the NE LAP, if you prefer to not be held to these standards, you may decline to receive services from the NE LAP. No report shall be made to the Division of your decision to not use NE LAP services. Once you have consented to receive NE LAP services, you authorize this full disclosure if either determination is made by the NE LAP. Your confidentiality rights are expressly limited by this Nebraska law for the NE LAP. Should you rescind your consent to receive services during the course of your NE LAP services and revoke your authorization to the Division of Public Health, the NE LAP will only report your decision to discontinue with NE LAP services to the Division.

Your consent to receive NE LAP services signature below indicates that you have read this *Notice* and you understand that the NE LAP will make a report to the Division of Public Health if either determination described above is made in your case and you authorize full disclosure of your NE LAP information to the Division of Public Health following that determination.

Consent to Receive Services		Decline to Receive Services	
Signature:	_____	Signature:	_____
Date:	_____	Date:	_____
Witness:	_____	Witness:	_____

NEBRASKA LICENSEE ASSISTANCE PROGRAM
Authorization to Release Information

I, _____, in order for the Nebraska Licensee Assistance
(Name of NE LAP client)
Program (NE LAP) to have the information and communication necessary to provide my NE LAP services, authorize and request the NE LAP to release to and receive information from (please check all that apply):

_____ NE Professional Health Services Licensing Board_____

_____ NE DHHS, Div. of Public Health, Investigations Unit_____

_____ NE DHHS, Div. of Public Health, Licensure Unit _____

_____ Employer/Human Resources/Supervisor_____

_____ Treatment Provider_____

_____ NE Occupational Health (body fluid screen program)_____

_____ Nebraska Attorney General's Office_____

_____ Other_____

Specific information to be provided is to consist of (check appropriate area):

_____ All available information regarding my case, including all alcohol and substance use information.

_____ Re-release of all other providers' alcohol/substance use assessments/evaluations, progress reports and discharge summaries that I have made available to the NE LAP.

_____ Other (please specify) _____

This authorization is effective for twelve months from the date signed, or on _____, as I have requested, to fulfill the purposes of this authorization, unless sooner revoked. Information released according to the authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations. I understand I may revoke this authorization at any time by notifying the NE LAP Coordinator, NE LAP counselor, NE LAP Clinical Manager, or the Corporate Director of the NE LAP of my revocation of this authorization. Release of information will cease upon receipt of my revocation. I understand such revocation will not apply to information that may have been released prior to revocation. The NE LAP cannot condition NE LAP services based on agreement to this authorization to release information.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____ _____
Date NE LAP Client Signature

_____ _____
Date Witness Signature