

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

MAY WE COMMUNICATE WITH YOU VIA EMAIL? YES NO EMAIL _____

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
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

(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
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself - - or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
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 than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way

(For office coding: 0 + ____ + ____ + ____ = Total Score: ____)

If you circled any problems, how difficult 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
- Nebraska Licensee Assistance Program
- Best Care EAP
- Community Counseling Program

The contact information of the MHS Privacy Officer is found below:

Privacy Officer – (402) 354-6863
compliance@nmhs.org

The programs and services listed above will share your clinical information with each other, as applicable, to carry out treatment, payment and health care operations.

Understanding Your Record/Clinical Information

Every time you have an appointment with a counselor from one of the programs listed above, a record of your visit is made.

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. To exercise any of the following rights, please contact the Privacy Officer at the above number:

- You have a right to expect that your clinical information will be kept secure and used only for legitimate purposes.
- You have a right to receive this privacy notice that explains how your clinical information may be used or disclosed.
- You have a 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 a 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 a right to request we not use or share certain clinical information you consider especially sensitive for counseling, payment or our health care operations. You also have the right to request that 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 this 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.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes;
- Sale of your information;
- Most sharing of psychotherapy notes

We must disclose your health information to you, as described in this Notice. You may also give us written authorization to use your health information or to disclose it for any purpose. You may revoke your authorization at any time by contacting the Privacy Officer at the number listed above, but your revocation will not affect any use or disclosure made by us in reliance on your authorization. Without your written authorization, we may not use or disclose your medical information for any reason except those described in this Notice.

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 Treatment, Payment and Health Care Operations

When state or federal law requires us to obtain your written permission to use or disclose your information for your treatment, payment or health care operations, we will do so. However, there are also situations where we may use or disclose your information for treatment, payment and health care 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.

For example: Members of the clinical staff or members of the quality improvement team may use information in your health record to assess your care and outcomes. This information is used in our ongoing efforts to improve the quality and effectiveness of the health care and 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 veteran's 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.

Workers' Compensation: We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care about your location and general condition.

Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the Methodist Health System (MHS) Privacy Officer at (402) 354-6863 or compliance@nmhs.org. If you believe your privacy rights have been violated, you can file a complaint with the MHS Privacy Officer using the contact information above 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 2019

Nebraska Methodist Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-599-4863.

注意：如果您使⊠ 繁體中⊠，您可以免費獲得語⊠ 援助服務請致電 844-599-4863。

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

Signature: _____

Date: _____

Witness: _____

Decline to Receive Services

Signature: _____

Date: _____

Witness: _____