

ALTERNATIVES Client Information Form

Please Fax (816-472-9016) or Send Form When Case is Closed

PERSONAL INFORMATION	CLIENT NAME _____ CASE # _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ AGE _____ DATE OF BIRTH _____ GENDER(M/F) _____ EDUCATION (Years Completed) _____ TELEPHONE (WORK) _____ (HOME) _____ (CELL) _____ FOLLOW-UP CALL OKAY? _____ MOTIVATION TO USE EAP <input type="checkbox"/> RELATIONSHIP <input type="checkbox"/> MARITAL STATUS <input type="checkbox"/> ETHNIC GROUP <input type="checkbox"/> REFERRAL SOURCE <input type="checkbox"/> 1. Training/Ed Program 1. Employee 1. Single 1. Hispanic 1. Self 2. Publication/Pamphlet 2. Spouse 2. Married 2. African American 2. Company Mandatory 3. Word of Mouth 3. Dependent 3. Divorced 3. Caucasian 3. Caucasian 4. EAP Web Site 4. Other 4. Widowed 4. Asian 4. Asian 5. Union 5. Native American 6. Company Suggestion 6. Other
COMPANY INFORMATION	COMPANY NAME (Of Covered Employee) _____ POSITION <input type="checkbox"/> JOB CLASSIFICATION <input type="checkbox"/> UNION <input type="checkbox"/> LENGTH OF SERVICE <input type="checkbox"/> 1. Production 1. Manager 1. Union (In Years) 2. Service 2. Supervisor 2. Non Union 3. Professional 3. Emp/Associate 4. Technical 5. Marketing/Sales 6. Office/Clerical
SERVICE & OUTCOME INFORMATION	SERVICE AREA (Primary Issue) <input type="checkbox"/> REFERRAL TO <input type="checkbox"/> OUTCOME <input type="checkbox"/> 1. Alcohol/Drugs 8. Elder Care 1. No Referral, EAP (When Closing) 2. Other Addiction 9. Medical Counseling 1. Resolved 3. Emotional/Psyc. 10. Work Related 2. Other EAP Service 2. Improved 4. Marital/Family 11. Vocational 3. Inpatient Treatment 3. Unimproved 5. Legal 12. Coaching 4. Outpatient Treatment 4. Withdrew/No Feedback 6. Financial 13. Other 5. Outpatient Counseling 7. Child Care 6. Community Resource
CASE CLOSING & INVOICING INFORMATION	When you close the case please designate the outcome (above), the dates of service, and the closing date (below). For your convenience this form can be used as invoice. Fax it to 816-472-9016 or if you prefer, please send us this completed form with your invoice. If you have any questions, please contact the Vice President of Clinical Services at 816-753-8283 Extension 222. DATES OF SERVICE _____ SEND PAYMENT TO (please include affiliate name or group) _____ _____ _____ HOURS _____ RATE \$ _____ TOTAL AMOUNT \$ _____ CLOSE DATE _____