SAN FRANCISCO
HEALTH SERVICE SYSTEM
Better Every Day.

EMPLOYEE ASSISTANCE PROGRAM

Client Information Form

REV01092019

1. **Today's date** _____

2. **Your name (Last, First, M.I.)**

   _____

   If you recently changed your name, what was your previous last name? _____

3. **Last 4 of your Social Security #** _____

4. **Your City/County status**
   - ☐ City/County employee
   - ☐ Family/significant other of City/County Employee
   - ☐ Pre-employment evaluation
   - ☐ Other City/County status (describe below)

   _____

5. **If you are a family member or significant other of a City/County employee, complete the following:**

   I am the employee's (e.g. wife, son, partner)

   _____

   Employee's name (Last, First, M.I.)

   _____

   Last 4 of Employee's Social Security #

   _____

6. **Phone number** ( )_____
   May we leave a voice mail message?
   Yes ☐ No ☐

7. **Work phone number** ( )_____
   Is it okay to call you at work?
   Yes ☐ No ☐
   May we leave a voice mail message?
   Yes ☐ No ☐

8. **Home address** (street address, city, zip)

   _____

   _____

   _____

9. **Work Location/Address**

   _____

   _____

10. **Person to contact in emergency**

    Name _____

    Relationship to you _____

    Phone number ( ) _____

    Address if different from yours

    _____

    _____

11. **Email Addresses (Check preferred email)**
    - ☐ Personal _____
    - ☐ Work _____

12. **Gender**
    - ☐ Female
    - ☐ Male
    - ☐ Other _____

13. **Which best describes your current relationship status?**
    - ☐ Single, never married
    - ☐ Married/registered domestic partners
      How long? _____
    - ☐ Living together/domestic partners
      How long? _____
    - ☐ Separated – How long? _____
    - ☐ Divorced – How long? _____
    - ☐ Widowed – How long? _____

14. **Your sexual orientation**
    ☐ Gay ☐ Lesbian ☐ Bi-sexual ☐ Heterosexual
    ☐ Other _____

15. **Age and gender of your dependents (if any)**

    _____

16. **Your date of birth** _____ **Age** _____

17. **Highest level of education** _____

Client Information Form

18. Race/ethnic origin

- ☐ African American
- ☐ Caucasian
- ☐ Chinese
- ☐ Filipino/Filipina
- ☐ Japanese
- ☐ Latino/Latina
- ☐ Native American
- ☐ Vietnamese
- ☐ Other Asian/Pacific Islander
- ☐ Mixed race/other: _____

19. Which City/County health insurance do you have?

- ☐ City Plan
- ☐ Kaiser
- ☐ Blue Shield
- ☐ None

20. Are you covered by another health insurance plan?

- ☐ Yes (name of plan) _____
- ☐ No

21. Are you eligible for Veteran's benefits?

- ☐ Yes
- ☐ No

Instructions for questions 22 – 34:

City/County Employees – please complete the following questions as they apply to you. Family members or significant others, complete the questions as they apply to the employee.

22. Department _____

23. Division (if applicable) _____

24. Employment status

- ☐ Full-time
- ☐ Part-time
- ☐ Temporary/as-needed

25. On permanent or provisional status?

☐ Permanent ☐ Provisional

26. On probation?

☐ Yes ☐ No

27. Job class #/title _____

28. Is this a Department of Transportation safety-sensitive position? ☐ Yes ☐ No

29. Occupation

- ☐ Executive/administrator/manager
- ☐ Professional/technician
- ☐ Supervisor
- ☐ Paraprofessional
- ☐ Office/clerical worker
- ☐ Machine/transport operator
- ☐ Skilled craft worker
- ☐ Service worker
- ☐ Laborer

30. Shift

- ☐ Do not work shifts
- ☐ Day
- ☐ Evening
- ☐ Graveyard/night
- ☐ Rotational
- ☐ Split shift

31. Union member

☐ Yes ☐ No

Name & local # of union _____

32. Number of years you have worked for the City/County? _____

33. Who referred you to the EAP?

- ☐ Self-referred
- ☐ Family member/significant other
- ☐ Co-worker
- ☐ Supervisor/Manager
- ☐ Human Resources
- ☐ Union Representative
- ☐ Other: _____

34. On a scale of 1 to 10, where 10 is the most productive you have ever been, how would you rate your overall performance at work during the past 4 weeks? _____

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CONSENT FOR SERVICES

VOLUNTARY

I, _____ voluntarily consent for evaluation, assessment, screening and/or intervention with the San Francisco Health Service System Employee Assistance Program (EAP.) I understand that 6 sessions in a 12 month period are available to me so long as it is deemed appropriate by my counselor. I understand that appointments must be scheduled in advance and that if I want to reschedule or cancel, I must call 24 hours prior to my appointment time. If I do not show up and have not cancelled, the "no show" will count as one of my 6 sessions.

CONFIDENTIALITY

I understand that records concerning the services I receive will be kept by the EAP. Professional ethics and state laws (California Welfare and Institution Code 93-292, Title 42, Sections 5328 and 5330) mandate that these records will be kept confidential. On occasion, your EAP counselor may need to communicate by electronic means. Any emails sent will be sent SECURE/encrypted.

I understand that California State Law requires that Licensed Marriage & Family Therapists break confidentiality in specific instances:

California Evidence Code 1024 states that a therapist (counselor) may break confidentiality "…if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger."

Additionally, in accordance with California Law, I understand that if my EAP counselor has reasonable suspicion about child abuse, elder abuse and/or disabled or dependent adult abuse, the counselor is required by law to report to the appropriate agency(s). Therefore, if in the course of my work with the EAP counselor I reveal such information, it will be reported to the appropriate protective agency(s).

Further, I understand that under Section 215 of the Patriot Act, if an FBI agent presents a national security letter compelling my therapist's (counselor's) compliance with the Patriot Act, the therapist must provide FBI agents with any items that are requested. The therapist is prohibited from disclosing to the patient or anyone else (who could reasonably inform the patient) that the subpoenaed items were either sought or obtained.

_____

Client Initials

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COORDINATION OF CARE

I understand that if I am under the care of a physician, health care provider and/or another therapist, I will need to discuss this with my EAP counselor (therapist.) To provide coordinated care, a written "Release of Information" form or "Authorization to Exchange Confidential Information" form may be required to allow the EAP counselor to talk to my other health care provider(s).

EMERGENCIES

I understand that while I am receiving services from the EAP, it I have a mental health or substance abuse emergency, I can, during normal EAP business hours (M-F 8:00 – 5:00) contact my EAP counselor at (415) 554-0610 or (800) 795-2351. If a counselor is not available or if I do not desire to contact EAP, I will call 911 or go to the nearest hospital emergency room to seek services.

QUALITY OF SERVICES

I understand that getting the most out of EAP services requires that I fully participate and promptly communicate any concerns about the quality of services to my EAP counselor who will be glad to discuss it with me.

CONSENT

Your signature below indicates that you have read this "Consent for Services" and understand it. If you have any concerns or questions you would like addressed before signing this Consent for Services, please inform your EAP counselor.

NOTE: Employees seeking Telecounseling services may provide written or verbal consent.

I have read and agree to the terms of this Consent for Services:

_____ _____

Client Signature **Date**

_____ _____

Counselor Signature **Date**