

**FirstHealth of the Carolinas Employee Assistance Program (FHC-EAP)**

PO Box 3000, Pinehurst, NC 28374

(910) 715-3444 or 1-888-278-4595 FAX (910) 715-3414

**Affiliate Services Case Closing Report Form**

Affiliate Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Affiliate Address: \_\_\_\_\_  
\_\_\_\_\_

Please include an Invoice with your letterhead to include total number of sessions at hourly contracted rate.

**Client Name(s):** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**You MUST list date & specify NAME and relationship of ALL persons present for EACH session.**

\*\*\* If anyone under age 21 was seen, also list their age and birthdate next to name and relationship.

Session#1 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ In attendance: \_\_\_\_\_

Session#2 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ In attendance: \_\_\_\_\_

Session#3 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ In attendance: \_\_\_\_\_

Session#4 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ In attendance: \_\_\_\_\_

Session#5 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ In attendance: \_\_\_\_\_

**Problem Area:** 1=Primary 2=Secondary (Also place an "x" next to additional problems addressed)

\_\_\_\_ Psych/Emotional \_\_\_\_ Marriage/Relationship \_\_\_\_ Family/Child \_\_\_\_ Alcohol/Drugs  
\_\_\_\_ Financial \_\_\_\_ Legal \_\_\_\_ Abuse \_\_\_\_ Job \_\_\_\_ Medical \_\_\_\_ Other \_\_\_\_\_

**Severity at Assessment:** \_\_\_\_ Mild \_\_\_\_ Moderate \_\_\_\_ Severe

**Resolution at Closure:** \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_ Other Closure Status: \_\_\_\_

**Threat of Harm:**

**Self:** \_\_\_\_ Denied \_\_\_\_ Discussed \_\_\_\_ N/A **Others:** \_\_\_\_ Denied \_\_\_\_ Discussed \_\_\_\_ N/A

If so, Notes and action plans: \_\_\_\_\_

**Case Outcome (check only one)**

\_\_\_\_ EAP Only, Goals Met at Affiliate Office  
\_\_\_\_ EAP only, Incomplete, Client dropped out  
\_\_\_\_ Referral Declined or Incomplete  
\_\_\_\_ Referral Made & Completed

**Referred to:** type of resource \_\_\_\_\_  
Name: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_  
Other: \_\_\_\_\_

\* \* **If client continues with you,** the FHC-EAP Referral Acknowledgment form must be signed by client & returned to FHC-EAP.

**Case Summary:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Affiliate Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>FHC-EAP Office Use Only</b>	
All paperwork complete & OK'd for Billing: by _____	Date: ____/____/____ Fee per session \$ ____ Total Fees \$ ____
Comments: _____	