

Paperwork Instructions Sheet:

NOTE: Clients should not be seen more frequently than one time per week without prior authorization by the Case Management department.

COMPLETING THE PAPERWORK

Due after the initial session:

- Paperwork only required for the identified primary client
- Client Assessment forms (both pages) : Answer sections 1 – 3 and the initial section of part 4

SUBMITTING YOUR BILL

IN ORDER TO RECEIVE PAYMENT, THE FOLLOWING FORMS ARE REQUIRED:

- Client Assessment Form (two-pages)
- AWP InvoiceSheet

Please mail, fax, or upload completed forms to our Claims Department after the initial session.

For subsequent sessions, only the AWP Invoice Sheet will be required to receive payment.

At closing, please submit page 2 of the Client Assessment Form and include responses to the second half of Section 4, and all of sections 5, 6, and 7.

Paperwork and initial Invoice MUST be received within 90 days from each individual session date in order to receive payment. No payment will be remitted after 90 days. Paperwork may also be uploaded to the secure portal link listed below.

Secure Portal Submissions at www.awpnow.com

Claims Fax Number: (512) 306-0431

or

Alternate Fax Number: (512) 637-9933

Mailing Address:

Claims Department

C/O Alliance Work Partners

2525 Wallingwood Drive, Building 5

Austin, TX 78746

For questions regarding contracts, rates, or updated credentials:

For authorization of sessions or questions about referrals:

For questions about payment, paperwork, or billing:

Provider Relations: 1-800-522-0550

Intake: 1-800-343-3822

Claims: (512) 328-8518

CLIENT ASSESSMENT FORM

Please fill out and fax to (512) 306-0431 or send to 2525 Wallingwood Dr., Bldg 5, Austin Tx, 78746

(Please Print)

Page 1 of 2



CLIENT NAME:	RECORD #:
CLINICIAN'S NAME:	PHONE #:
	FAX #:

1 ➔ Using the list below, ENTER THE NUMBER corresponding to the primary Presenting problem and the primary assessed problem here.

EMOTIONAL / PSYCHOLOGICAL		RELATIONSHIPS / FAMILY		SUBSTANCE ABUSE		OCCUPATIONAL	
1	Stress	11	Relationships: Marital	21	Poly Drug Self	27	Career Planning
2	Anxiety	12	Relationships: General	22	Poly Drug Family Member	28	Tardiness Absence
3	Depression	13	Family: General	23	Alcohol Self	29	Quality / Quantity Work
4	Disability	14	Family: Children	24	Alcohol Family Member	30	Work Relationships
5	Eating Disorder	15	Family: Childcare	25	Drugs Self	31	Safety
6	Learning Disorder	16	Family: Elder Care	26	Drugs Family Member	32	Job Stress
7	Impulse Control Disorder	17	Family: Dom Abuse / trauma			33	Sexual Harassment
8	Thought Disorder	18	Legal			34	Other
9	Grief / Loss	19	Financial				
10	Situational / Adjustment	20	Medical				

PRESENTING PROBLEM:	ASSESSED PROBLEM:
ASSESSED PROBLEM SEVERITY AT OPENING:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

2

JOB DYSFUNCTION	<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Significant / no job jeopardy <input type="checkbox"/> Significant / job jeopardy												
JOB PROBLEM, MANDATORY REFERRAL ONLY	<table style="width:100%;"> <tr> <td><input type="checkbox"/> Absenteeism</td> <td><input type="checkbox"/> Tardiness</td> <td><input type="checkbox"/> Supervisor relationship</td> </tr> <tr> <td><input type="checkbox"/> Fitness for duty</td> <td><input type="checkbox"/> Positive drug screen</td> <td><input type="checkbox"/> Aberrant Behavior</td> </tr> <tr> <td><input type="checkbox"/> Safety Issues</td> <td><input type="checkbox"/> Productivity issues</td> <td><input type="checkbox"/> Work Performance</td> </tr> <tr> <td><input type="checkbox"/> Unpaid leave(s)</td> <td><input type="checkbox"/> Co-worker relationships</td> <td><input type="checkbox"/> None</td> </tr> </table>	<input type="checkbox"/> Absenteeism	<input type="checkbox"/> Tardiness	<input type="checkbox"/> Supervisor relationship	<input type="checkbox"/> Fitness for duty	<input type="checkbox"/> Positive drug screen	<input type="checkbox"/> Aberrant Behavior	<input type="checkbox"/> Safety Issues	<input type="checkbox"/> Productivity issues	<input type="checkbox"/> Work Performance	<input type="checkbox"/> Unpaid leave(s)	<input type="checkbox"/> Co-worker relationships	<input type="checkbox"/> None
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<input type="checkbox"/> Safety Issues	<input type="checkbox"/> Productivity issues	<input type="checkbox"/> Work Performance											
<input type="checkbox"/> Unpaid leave(s)	<input type="checkbox"/> Co-worker relationships	<input type="checkbox"/> None											

3 ➔ **ASSESSMENT OUTCOME**

<input type="checkbox"/> Did not complete Assessment
<input type="checkbox"/> Assigned to EAP short term counseling
<input type="checkbox"/> Referral Offered - Insurance
<input type="checkbox"/> Referral Offered - Community Resources
<input type="checkbox"/> No Referral needed

****COMPLETE ABOVE SECTIONS AFTER INITIAL APPOINTMENT****

CLIENT ASSESSMENT FORM

Please fill out and fax to (512) 306-0431 or send to 2525 Wallingwood Dr., Bldg 5, Austin Tx, 78746

(Please Print)

Page 2 of 2



CLIENT NAME:	RECORD #:
CLINICIAN'S NAME:	PHONE #:
	FAX #:

	4 ➔ GOALS (please print legibly):	↘ Complete at Opening:	↘ Complete at Closing:		
1		MET	PARTIALLY MET	NOT MET	NO CHANGE
2		MET	PARTIALLY MET	NOT MET	NO CHANGE
3		MET	PARTIALLY MET	NOT MET	NO CHANGE

5	ASSESSED PROBLEM SEVERITY AT CLOSING:	<input type="checkbox"/> Resolved	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
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6	➔ CASE DISPOSITION:
<input type="checkbox"/>	Face to face assess / no referral
<input type="checkbox"/>	Face to face assess / referral accepted – Insurance
<input type="checkbox"/>	Face to face assess / referral accepted – Non-insurance
<input type="checkbox"/>	Face to face assess / referral declined
<input type="checkbox"/>	EAP Participant did not keep initial appointment
<input type="checkbox"/>	EAP Participant withdrew before completion of services

7	➔ REFERRAL TYPE:					
<input type="checkbox"/>	No referral beyond EAP					
<input type="checkbox"/>	Substance abuse treatment	DETOX ONLY	INPATIENT	INTENSIVE OUTPATIENT (OP)	OTHER	
<input type="checkbox"/>	Psychiatric treatment	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT (NON MD)	OUTPATIENT (MD)	OTHER
<input type="checkbox"/>	Medical treatment					
<input type="checkbox"/>	Community resource					

▶ _____
COUNSELOR SIGNATURE

▶ _____
DATE

****COMPLETE ABOVE SECTIONS AFTER CLOSING****



You have 90 days from the date of EACH session to bill AWP. BILLS RECEIVED AFTER 90 DAYS WILL BE CONSIDERED LATE AND WILL NOT BE PAID.

AWP INVOICE SHEET

► Please fill out and fax to (512) 306-0431 or send to 2525 Wallingwood Dr., Bldg 5, Austin TX, 78746.



A professional service of Worker's Assistance Program, Inc.

CLIENT NAME:	RECORD #:
CLINICIAN'S NAME <i>(please print):</i>	Tax ID #:
Billing Address:	Phone #:
City / State / Zip:	Fax #:
MAKE CHECKS PAYABLE TO <i>(if different than above):</i>	

1	SESSION DATE:	SESSION NUMBER:	FEE:	
Please list all attendees in session below:		(SEE BOTTOM OF PAGE FOR LEGEND)		
Name:	D.O.B.:	RELATIONSHIP: S C R F SO P	GENDER: M / F	
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Name:	D.O.B.:	RELATIONSHIP: S C R F SO P	GENDER: M / F	

2	SESSION DATE:	SESSION NUMBER:	FEE:	
Please list all attendees in session below:		(SEE BOTTOM OF PAGE FOR LEGEND)		
Name:	D.O.B.:	RELATIONSHIP: S C R F SO P	GENDER: M / F	
Name:	D.O.B.:	RELATIONSHIP: S C R F SO P	GENDER: M / F	
Name:	D.O.B.:	RELATIONSHIP: S C R F SO P	GENDER: M / F	

3	SESSION DATE:	SESSION NUMBER:	FEE:	
Please list all attendees in session below:		(SEE BOTTOM OF PAGE FOR LEGEND)		
Name:	D.O.B.:	RELATIONSHIP: S C R F SO P	GENDER: M / F	
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ATTENTION

You have 90 days from the date of EACH session to bill AWP.

BILLS RECEIVED AFTER 90 DAYS WILL BE CONSIDERED LATE AND WILL NOT BE PAID.

► TOTAL FEES:

RELATIONSHIP LEGEND:	S: Spouse C: Child	F: Friend SO: Significant Other	R: Relative P: Parent
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