# 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: Provider Relations: 1-800-522-0550
For authorization of sessions or questions about referrals: Intake: 1-800-343-3822
For questions about payment, paperwork, or billing: 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)*



| | | |
|---|---|---|
| **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:** ☐ Mild ☐ Moderate ☐ Severe

**2**

| | | | | | |
|---|---|---|---|---|---|
| **JOB DYSFUNCTION** | ☐ None | ☐ Minimal | ☐ Moderate | ☐ Significant / no job jeopardy | ☐ Significant / job jeopardy |
| **JOB PROBLEM,** MANDATORY REFERRAL ONLY | ☐ Absenteeism | | ☐ Tardiness | | ☐ Supervisor relationship |
| | ☐ Fitness for duty | | ☐ Positive drug screen | | ☐ Aberrant Behavior |
| | ☐ Safety Issues | | ☐ Productivity issues | | ☐ Work Performance |
| | ☐ Unpaid leave(s) | | ☐ Co-worker relationships | | ☐ None |

**3** ASSESSMENT OUTCOME

- ☐ Did not complete Assessment
- ☐ Assigned to EAP short term counseling
- ☐ Referral Offered - Insurance
- ☐ Referral Offered - Community Resources
- ☐ 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)*



| 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:**

☐ Resolved ☐ Mild ☐ Moderate ☐ Severe

**6** **CASE DISPOSITION:**

- ☐ Face to face assess / no referral
- ☐ Face to face assess / referral accepted – Insurance
- ☐ Face to face assess / referral accepted – Non-insurance
- ☐ Face to face assess / referral declined
- ☐ EAP Participant did not keep initial appointment
- ☐ EAP Participant withdrew before completion of services

**7** **REFERRAL TYPE:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ No referral beyond EAP | | | | | |
| ☐ Substance abuse treatment | DETOX ONLY | INPATIENT | INTENSIVE OUTPATIENT (OP) | | OTHER |
| ☐ Psychiatric treatment | INPATIENT | PARTIAL HOSPITALIZATION | OUTPATIENT (NON MD) | OUTPATIENT (MD) | OTHER |
| ☐ Medical treatment | | | | | |
| ☐ Community resource | | | | | |

▶ _____

COUNSELOR SIGNATURE

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

▶ _____

DATE

**You have 90 days from the date of the 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

*(Please Print)*

| | |
|---|---|
| **CLIENT NAME:** | **RECORD #:** |
| **CLINICIAN'S NAME** *(PLEASE PRINT):* | **TAX ID #:** |
| Billing Address: | **PHONE #:** |
| City / State / Zip: | **FAX #:** |
| **MAKE CHECKS PAYABLE TO** *(If different than above):* | |

**1**

| **SESSION DATE:** | **SESSION NUMBER:** | **FEE:** |
|---|---|---|

**Please list all attendees in session below:** (SEE BOTTOM OF PAGE FOR LEGEND)

| | | |
|---|---|---|
| **Name:** | **D.O.B.:** | RELATIONSHIP: **C SO D O** |
| **Name:** | **D.O.B.:** | RELATIONSHIP: **C SO D O** |
| **Name:** | **D.O.B.:** | RELATIONSHIP: **C SO D O** |

**2**

| **SESSION DATE:** | **SESSION NUMBER:** | **FEE:** |
|---|---|---|

**Please list all attendees in session below:** (SEE BOTTOM OF PAGE FOR LEGEND)

| | | |
|---|---|---|
| **Name:** | **D.O.B.:** | RELATIONSHIP: **C SO D O** |
| **Name:** | **D.O.B.:** | RELATIONSHIP: **C SO D O** |
| **Name:** | **D.O.B.:** | RELATIONSHIP: **C SO D O** |

**3**

| **SESSION DATE:** | **SESSION NUMBER:** | **FEE:** |
|---|---|---|

**Please list all attendees in session below:** (SEE BOTTOM OF PAGE FOR LEGEND)

| | | |
|---|---|---|
| **Name:** | **D.O.B.:** | RELATIONSHIP: **C SO D O** |
| **Name:** | **D.O.B.:** | RELATIONSHIP: **C SO D O** |
| **Name:** | **D.O.B.:** | RELATIONSHIP: **C SO D O** |

**ATTENTION**

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

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

**RELATIONSHIP LEGEND:** C: CLIENT SO: SPOUSE/SO D: DEPENDENT O: OTHER