HEALTH AND HUMAN SERVICES GROUP
23392 Madero, Suite "L"
Mission Viejo, California 92691
1-800-275-7460 FAX (949) 855-7575

SUBMIT WITH EVERY BILL
One for each session!
PLEASE TYPE OR PRINT CLEARLY

AREA CLINICIAN MULTI-USE: (Clinical/Briefing/Training)
SERVICE RECEIPT – DEA EAP

Case Number: _____ Date Referred: _____ Clinician Name:_____

***1. EAP COUNSELING SERVICES*: Session #: _____ (1-6) Session Date:_____ Session Duration: _____ (Hours)**

DSM CODE: ☐ **GAF SCORE:** ☐ **Check if this is LAST Session:** ☐

Narrative Description of Session Goal and Accomplishment:_____

_____

_____

_____

_____

_____

Discharge Summary: If this is the *Final Session* please note any improvement and follow-up recommendations:

_____

_____

_____

_____

_____

Check one: Improved: ☐ Not Improved: ☐ Too soon to tell: ☐ **GAF Score Final)** ☐

***2. CLINICAL BRIEFING SERVICES*: Type Trauma: ☐ Operations ☐ Non-Operations**

A. Date of Session:_____ Debriefing Location: ☐ Your Office ☐ On Site ☐ Other (Describe Below)*
B. Session #: _____ (1-4) Session Duration: _____ Travel Time:_____ (Hours or 1/4hrs)
C. Clinical Briefing Services Provided to: ☐ Individual ☐ Group ☐ Family
D. Number of People Debriefed: _____

***3. TRAINING SERVICES PERFORMED*:**

A. Training No._____
B. Dates of Training: _____ Preparation Time: _____ Training Hours: _____ Travel Hours: _____
C. Training Subject: _____ Location of Training: _____
D. Number of Managers Trained: _____ Number of Employees Trained: _____

EXPENSE REIMBURSEMENT (Include receipts)

Mileage: _____ Rental Car: $_____ Per Diem: $_____ Lodging: $_____
Airfare: $_____ Tolls/Parking: $_____ Other: $_____

ACKNOWLEDGEMENT THAT SERVICES WERE RECEIVED AS LISTED ABOVE:

_____ _____ _____
Signature of Employee, or Family Member **Print Name of Employee or Family Member** **Session Date**

Therapist Name _____

_____ _____ _____
Signature of Manager (Training) **Print Name of Manager** **Date of Training**

Please Make Copies As Needed - FORM # 3b