HEALTH AND HUMAN SERVICES GROUP
25108 Marguerite Parkway, Ste. B #505
Mission Viejo, California 92692
1-800-467-3277 FAX (949) 768-1667

SUBMIT WITH EVERY BILL

PLEASE TYPE OR PRINT CLEARLY

U.S. DEPARTMENT OF HOMELAND SECURITY
Office of Border Patrol (OBP)

RECEIPT FOR SERVICES RENDERED

Case Number: _____ HQ Control #: _____ Date Referred: _____
(For Extended Sessions Only)

1. **EAP COUNSELING/MANAGEMENT CONSULTATION/MONITORING SERVICES:**
   - **A. Date of Session:_____ Session #: _____ (1-6) Session Duration: _____ (In Hours or 1/4hrs)**
   - **B. Services Provided: ☐ In Person ☐ Telephone ☐ On-Site ☐ Other**
   - **C. Narrative Description of Session Goal and Accomplishment:_____**

     _____

     _____

     _____

2. **CRITICAL INCIDENT TRAUMA SERVICES AND THREAT OF VIOLENCE (Complete CISM Report):**
   - **A. Date of Session:_____ Debriefing Location: ☐ Your Office ☐ D On Site ☐ Other (Describe Below)***
   - **B. Session #: _____ (1-6) Session Duration: _____ Travel Time:_____ (In Hours or 1/4hrs) Travel Cost: $_____**
   - **C. CISD Services Provided to: ☐ Individual ☐ Group ☐ Family D. Number of People Debriefed: _____**

3. **FOLLOW-UP ON CISD AND SUBSTANCE ABUSE CASES: (Clinicians will follow-up with clients once per month, up to 12 times, for all substance cases for employees who have successfully completed outpatient/inpatient treatment. Pilots completing substance abuse outpatient/inpatient treatment require 24 follow-up contacts. Client signatures not required for telephone follow-up. Telephone follow-up is limited to 15 minutes each and follow-up form must be submitted with billing)**
   - **A. Follow-up with: ☐ Individual ☐ Couple ☐ Family B. Contact Made: ☐ In Person ☐ Telephone**
   - **C. Contact Number: _____ (1-24) Duration of Contact: _____ (Min.)**

4. **TRAINING SERVICES PERFORMED**:
   - **A. Dates of Training: _____ Preparation Time: _____ Training Hours: _____ Travel Hours: _____**
     Rental Car Cost or Miles Driven Driven: _____ Airline Cost: $_____ Lodging Cost: $_____
   - **B. Training Subject: _____ Location of Training: _____**
   - **C. Number of Managers Trained: _____ Number of Employees Trained:_____**

5. **IS THIS THE LAST SESSION? ☐ Yes ☐ No *If YES, please include the Statement of Understanding and Consent AND Admission/Discharge Forms with this receipt.* Follow-up contacts (see #3 above) will be noted in future receipts.**

***COMMENTS (Use Another Sheet if More Space is Required):**

EMPLOYEE NOTICE
EAP SESSIONS FOR DHS EMPLOYEES ARE FREE, BASED ON THE NUMBER OF SESSIONS AUTHORIZED. SHOULD YOU RECEIVE A BILL FROM THE EAP COUNSELOR PLEASE REPORT IT TO US AT 1-800-467-3277.

I VERIFY THAT EAP SERVICES WERE RECEIVED AS SPECIFIED ABOVE:

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

Distribution: White-Clinician Yellow & Pink to HHSG