Advanced Practice Mental Health & Wellness
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Myrtle Beach 630 Chestnut Rd., Myrtle Beach, SC 29572	**Loris** 3997 Meeting St., Loris, SC 29569	**Florence** 2141 Hoffmeyer Rd., Florence, SC 29501
Georgetown 1837 N Fraser St., Georgetown, SC 29440	**Socastee** 4325 Dick Pond Rd., Myrtle Beach, SC 29588	**Little River** 4360 Big Barn Dr., Little River, SC 29566

WILSON SENIOR CARE EAP SERVICE REQUEST / INTAKE INTEREST FORM

This form is completed by the client and submitted to Advanced Practice Mental Health & Wellness (APMH) so EAP service authorization may be requested from Wilson Senior Care before covered services are scheduled.

CLIENT INFORMATION

Full Name:		**Date of Birth:**	
Phone Number:		**Email:**	
Address:		**City/State/Zip:**	
Wilson Senior Care Employee Name:		**Relationship:**	☐ Employee ☐ Spouse ☐ Dependent

REQUESTED EAP SERVICES

Service preference: ☐ Counseling/Therapy ☐ Medication Management ☐ Both ☐ Not Sure	Preferred appointment type: ☐ In Office ☐ Telehealth (if eligible/approved)
Preferred location: ☐ Myrtle Beach ☐ Loris ☐ Florence ☐ Georgetown ☐ Socastee ☐ Little River	Main reason for request (check all that apply): ☐ Stress/Anxiety ☐ Mood/Depression ☐ Grief ☐ Family/Relationship ☐ Work Concern ☐ Substance Use ☐ Other: _____
Preferred days/times: _____	Additional note for scheduling only: _____

AUTHORIZATION TO REQUEST EAP SERVICE APPROVAL

I request EAP services through Wilson Senior Care and authorize APMH to submit this form to Wilson Senior Care or its designated EAP contact for the limited purpose of verifying eligibility and requesting authorization for services. Information that may be disclosed for this purpose includes my name, date of birth, contact information, relationship to the Wilson Senior Care employee, requested service type, and appointment attendance/dates of service if required for EAP administration. APMH will not disclose psychotherapy notes, detailed clinical information, diagnosis, or treatment content without a separate written authorization, except as required or permitted by law. I understand EAP approval must be received before covered services are scheduled and that missed appointment/late cancellation fees or non-covered services may be my responsibility.

CLIENT ACKNOWLEDGEMENT AND SIGNATURE

Client/Guardian Signature:		**Date:**	
Printed Name:		**Relationship if Guardian:**	