Franciscan HEALTH

# *Employee Assistance Program*
# STATEMENT OF UNDERSTANDING

## PROGRAM SERVICES:

The Employee Assistance Program (EAP) is provided by your employer without cost to you to assist in clarification of personal problems. The EAP may also identify appropriate resources or services in the community for resolution of the problems you discuss with the EAP personnel. The EAP will monitor that service to ensure that your needs are being met. It is your responsibility to pay for services provided by any outside resources. Your health insurance may defray some of the cost of services provided by any outside resources. Consult your group insurance office if you have any questions regarding your insurance coverage.

## MANAGEMENT REFERRALS:

The EAP will not advise management of your participation in the EAP unless you are referred by management due to a work performance problem. Should that be the case, the EAP will confidentially advise your management that you are coming to the EAP.

## VOLUNTARY PARTICIPATION:

Use of the program is voluntary. In the event that you have been referred by management for EAP services, refusal to accept or utilize the EAP is not, in itself, a cause for disciplinary action. However, such refusal or failure to accept help may be taken into consideration in the evaluation of subsequent unsatisfactory performance or behavior.

## CONFIDENTIALITY:

The EAP will not reveal information that you disclose to EAP personnel to anyone outside the EAP except in the following circumstances:

(1) you consent in writing; (2) the law requires disclosure (generally, the law does not require information to be released unless life or safety is seriously threatened); (3) the EAP discerns a threat to security of the company or to a third party; and/or (4) insurance verification/claims certification is required.

I have read this statement and understand its content.

| _____ | _____ | ____/____/____ |
|---|---|---|
| **Printed Client Name** | **Client Signature** | **Date** |

***A Parental /Legal Guardian signature is required if the client is a minor under the age of 18.***

_____
**Minor Client Printed Name**

| _____ | _____ | ____/____/____ |
|---|---|---|
| **Parent / Legal Guardian Printed Name** | **Parent / Legal Guardian Signature** | **Date** |

For Office Use Only

**Scanned to File:** ☐**L.M.** ☐ **B.R.** ☐ **J.H.** ☐ **D.D.** ☐ **E.G.** ☐ **C.F.** **Date:**____/____/____