FIRST SUN EAP

We Help People Be Better at Work

HOW TO USE THE WORKPLACE REFERRAL FORMS

Thank you for your collaboration on this workplace issue. The four forms in this packet make a workplace referral successful. In addition, appropriate signatures are required for compliance with HIPAA regulations.

1. **Workplace Referral Form**. Please complete and return to a risk manager. Also, share it with your employee when you have your meeting. It ensures that everyone is aware of the workplace concerns and expectations for improvement.

2. **Statement of Understanding Regarding Workplace Referrals to First Sun EAP**. This form tells the employee about the EAP as a resource to help them get back on track in the workplace. It also tells them the limits to confidentiality. If you have determined this referral is your employee's last opportunity to correct performance or behaviors, please attach a copy of your Last Chance Agreement or Final Written Warning for our reference. Some of these referrals may involve violation of federal regulations or of company policies or may have implications for ADA or FMLA. We will consult with you about these issues. In any case, have the employee note that they are choosing to **use** or **not use** the EAP, and **sign and date the form. You are to sign as a witness.**

3. **Formal Workplace Referral Release of Information**. This form reaffirms that we will follow up with you about your employee's compliance with EAP recommendations. First Sun will not share any personal health or clinical information. Please write in a time by which the employee is to contact the risk manager you've been in contact. The employee should call 803-376-2668 or (toll free) 800-968-8143 and ask specifically for the risk manager by name. If not immediately available, the employee should leave a clear, distinct message on the confidential voicemail noting his/her name, the time of the call and how the risk manager can return the call.

4. **Consent Form for Substance Use Referrals to First Sun EAP.** This form is an additional Release of Information that allows First Sun EAP to communicate with the workplace and any treatment providers about any case that is substance use related. Due to federal law regulating alcohol and drug records, this release is necessary for us to share information with the workplace about an employee's participation in services.

   Please note that we have also included two **Provider Authorizations to Release Information (one is specific to substance use information) to this packet. Due to our use of telehealth services during this time, we need to secure the provider releases from the workplace so that we can continue to effectively case manage this referral. This form does **not** need to be signed by management or HR. We will forward it to the provider for his/her records.

   Please fax these forms back to First Sun EAP after you have met with your employee. Our fax number is 803-799-3772. Please note that our incoming email is currently not secure, so please do not send confidential information,including the employee's name via email.

Again, thank you for your time and collaboration on this matter. We hope that by working together in this team approach, your employee will get back on track and will be able to work safely and productivity.

WORKPLACE REFERRAL FORM

(Referral documents should be maintained in a file separate from the employee's personnel file.)
800-968-8143 or 803-376-2668

FOR FIRST SUN EAP USE ONLY

Employee _____ Company _____ Date_____
Job Title _____ Department _____ Phone # _____
Length of Time with: a) Company _____ b) Current Job _____
Current Supervisor Name _____ Phone # _____
Primary Contact Person _____ Title _____ Phone # _____

REASON FOR REFERRAL

Please indicate current workplace problem area(s).

UNPROFESSIONAL BEHAVIOR

- ☐ Frequent or intense arguments
- ☐ Verbal abusiveness
- ☐ Threatening or intimidating behavior
- ☐ Policy violation
- ☐ Rude/abrasive behavior
- ☐ Other (Please describe under Comments.)

ABSENTEEISM

- ☐ Excessive absenteeism
- ☐ Frequent unscheduled leave requests
- ☐ Frequent sick leave or illness on the job
- ☐ Excessive lateness/leaves early
- ☐ Other (Please describe under Comments.)

JOB PERFORMANCE

- ☐ Lower quality of work
- ☐ Decreased productivity
- ☐ Erratic performance
- ☐ Increased errors
- ☐ Incomplete work
- ☐ Impaired judgment, memory or ability to concentrate
- ☐ Failure to follow procedures
- ☐ Failure to meet schedules
- ☐ Other (Please describe under Comments.)

SAFETY

- ☐ Safety violations or accidents
- ☐ Self-reported alcohol or other drug use
- ☐ Talk of death or suicide
- ☐ Sudden mood swings (tearful, angry)
- ☐ Other (Please describe under Comments.)

POSTIVE DRUG SCREEN

Date of test _____ Type of drug(s) _____
Level(s) _____

COMMENTS RELATING TO CURRENT WORKPLACE ISSUES (Additional workplace documentation provided to First Sun EAP may be given to EAP providers as part of the referral process.)

DESIRED IMPROVEMENT (Describe what the employee must do to achieve satisfactory performance. Include time frame for improvements.)

CONSEQUENCES IF IMPROVEMENT IS NOT ACHIEVED

PREVIOUS STEPS OR DISCIPLINARY ACTION TO ADDRESS THIS ISSUE

HAS THERE BEEN A PREVIOUS JOB PERFORMANCE REFERRAL TO THE EAP? ☐ Yes Date _____ ☐ No

STATEMENT OF UNDERSTANDING

Regarding Workplace Referrals to First Sun EAP

800-968-8143 or 803-376-2668

When referrals to the Employee Assistance Program (EAP) are made because of workplace concerns, all parties (the company, employees and EAP consultants) have the same goal … **to resolve workplace problems**.

One or more company representatives have discussed your current workplace problem(s) and workplace history with employee assistance program staff. **Discussions of workplace concerns between and among the involved parties *will continue* in order to clarify workplace issues and to monitor progress toward problem resolution.** This communication may include workplace documentation (i.e. written disciplinary action, performance improvement plans) that is provided to First Sun EAP by your workplace. This documentation may also be shared with EAP resources, as needed.

The company offers EAP services to you as a means for you to get assistance in resolving workplace problems. Participation in the EAP does not restrict the company's right to take disciplinary measures. In addition to continuing discussions about progress toward resolving workplace concerns, an EAP consultant will inform the company whether or not you are using EAP services and if you are following the EAP recommendations. Records and details about your personal clinical issues are confidential and are not shared with the company or anyone else without additional permission, except as may be required by state laws, federal laws or applicable regulations (DOT, NRC, DOD etc.) For example, EAP consultants are required to:

1. Report evidence of child or elder abuse.
2. Take appropriate action if a person is assessed to be a danger to self or others.
3. Take appropriate action if a person poses a safety or security risk at the workplace.
4. Respond to subpoenas from a court or a workers' compensation review committee.
5. Release information or documents relating to an employee's compliance with DOT, NRC, DOD, or other applicable regulations.

☐ **Formal Referral**

I understand the EAP offers assistance in resolving workplace problems. Job performance matters will continue to be reviewed on their own merits by your employer. I have read or had explained to me the *Statement of Understanding Regarding Job Performance Referrals to the EAP* and understand its contents.

I am voluntarily choosing to ☐ **Use** ☐ **Not use** the EAP at this time.

_____	_____	_____	_____
Employee Signature	Date	HR/Supervisor Signature	Date

FORMAL WORKPLACE REFERRAL

Release of Information

800-968-8143 or 803-376-2668

Company: _____ Date: _____

I,_____ , understand that I am being referred to
Employee Name

FIRST SUN EAP for problems and/or safety concerns in the workplace. I understand that I must contact

_____ , by _____ to schedule an appointment.

Information to be released includes but may not be limited to:

1. Scheduled appointments and attendance
2. Recommendations pertinent to resolution of identified workplace problems
3. Compliance with these recommendations
4. Completion of EAP recommendations

I authorize FIRST SUN EAP to release this information to:

_____
Name of Referring Supervisor/Manager/HR Liaison (Please Print)

_____ _____
Phone Number(s) Email Address

I understand that this referral is part of an effort to improve job performance and/or workplace behaviors. Should sessions be needed beyond EAP benefits to resolve workplace issues, I understand that I will be responsible for any applicable EAP or insurance co-payments. I also understand that I may be billed for sessions missed without prior cancellation. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one year from today's date.

_____ _____ _____
Employee Signature Print Name Date

_____ _____ _____
Supervisor/Employer Signature Print Name Date

PRIOR TO THE FIRST EAP VISIT, please fax this form to _____
at FIRST SUN EAP • FAX (803) 799-3772

EMPLOYER/PROVIDER CONSENT FORM

Specific to Substance Use Referrals to First Sun EAP

800-968-8143 or 803-376-2668

(For HIPAA compliance, this form is to be used in addition to the Authorization to Release Confidential Information and the Formal Workplace Release of Information Forms)

I, _____ authorize First Sun EAP Alliance, Inc. to disclose information regarding
Employee Name

my use of substances that may pose safety risk or policy violation, including any available test results to:

a. _____, to ensure compliance with all company policies regarding substance use and

b. *All providers* involved with my treatment* for the purpose of assessment, treatment and case management of the referral.

This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already acted in reliance on it. If not previously revoked, this consent will terminate one year from today's date.

Employee Signature: _____ Date: _____

Witnessed By: _____ Date: _____

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65

***Please note**: This release does NOT give the provider permission to speak to the company. All reports MUST come through the EAP risk manager.*

Please fax this form back to the risk manager at (803) 799-3772.

FIRST SUN EAP

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION TO OR FROM FIRST SUN EAP ALLIANCE

I, _____ do hereby authorize *all providers involved in my services to release to First Sun EAP
(Client or representative) (Releasing party and agency)

the following information: assessment and treatment recommendations, scheduled appointments and attendance, compliance with recommendations.

The above information is to be released for the following purpose: case management
This authorization will expire one year from date of signature unless revoked before that time.

Records and details about your personal clinical issues are confidential and are not shared with the company or anyone else without additional, written permission, except as may be required by state laws, federal laws or applicable regulations (DOT, NRC, DOD etc.) For example, EAP consultants are required to:

1. Report evidence of child or elder abuse.
2. Take appropriate action if a person is assessed to be a danger to self or others.
3. Take appropriate action if a person poses a safety or security risk at the workplace.
4. Respond to subpoenas from a court or a workers' compensation review committee.
5. Release information or documents relating to an employee's compliance with DOT, NRC, DOD, or other applicable regulations.

INFORMATION ABOUT YOUR RIGHTS

I have read and understand the following statements about my rights:

- **I may revoke this authorization at any time** prior to its expiration date by notifying the releasing party in writing, but the revocation will not have any effect on any actions the releasing party took before it received the revocation.
- **I may review, obtain a copy, amend or see an accounting of disclosures** for any of the information requested here or in my record if I request such.
- **I am not required to sign this form in order to receive services from First Sun EAP.**
- I understand that if the person(s) or entity(ies) receiving the information is not a health care provider or health plan covered by federal privacy regulations, **the information described above may be redisclosed and is no longer protected by those regulations**. I have the right to seek assurances from the above-named recipients that they will not redisclose the above information to any other party without my further authorization.
- I am entitled to receive a copy of this authorization.

_____
(Signature of Client)

PLEASE FAX BACK TO _____ AT (803) 799-3772 Thank You!

Provider/Facility Consent Form for Substance Use Referrals to First Sun EAP

(For HIPAA compliance this form is to be used in addition to the Authorization to Release Confidential Information and the Formal Workplace Release of Information Forms)

I, _____ authorize First Sun EAP to disclose information regarding my use of substances, including any available test results to *all providers involved in my services for the purposes of assessment, treatment and/or recommendation for treatment.

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one year from today's date.

Employee's Signature:_____Date:_____

Witnessed By:_____Date:_____

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65

Please fax this form back to _____ at (803) 799-3772