



STATEMENT OF UNDERSTANDING

The First Advantage Employee Assistance Program ("EAP") provides problem-solving services to employees and their eligible family members ("clients") through Local Network Affiliates ("LNAs.") These services include interventions relating to stress management, substance abuse, family issues and other interventions that the EAP deems necessary for problem resolution. Other services provided include child/elder care information and referral, legal and financial counseling and other non-health related services.

FEES

Services provided by the EAP are offered at no direct cost to clients. The employee's company has already paid for the services. If assistance beyond the scope of services directly available through the EAP is needed, the LNA will help locate appropriate community resources. If the employee's company policy allows the client to continue seeing the LNA beyond the allotted EAP sessions, the client may choose to remain with this practitioner/practice. The client will be provided with other options. If the client chooses to remain with the LNA, the client will be financially responsible for all service provided beyond the allotted EAP sessions. A client's insurance may defray some of the cost of services beyond those provided by the EAP, but it is the client's responsibility to assume costs not covered by this insurance.

FEEDBACK/RELEASE OF INFORMATION

Information concerning use of the EAP services will not be part of the client's personnel record and will not be disclosed except as described below:

Self-Referrals: If any employee or family member voluntarily comes in for assistance, no information concerning the content of a person's EAP sessions will be discussed or released to anyone other than the LNA without the client's written permission.

Supervisor Referrals/Medical Referrals/Mandatory Referrals: If an employee is referred by his/her supervisor, medical or human resources department of his/her company, and signs a release of information, the EAP will only discuss with the company's personnel designated to monitor such referrals, (a) the reasons for the referral, (b) its recommendations, (c) the client's participation in the program, and (d) the client's compliance with the EAP's recommendations. Without a release of information, the EAP will only confirm EAP participation, i.e. the scheduled appointment was kept. In addition, the EAP will not discuss the employee's personal problems with the supervisor/medical/HR personnel without the employee's written permission.

Public Safety: If you work in a safety sensitive position and you self identify as a substance abuser or are identified as a substance abuser at any point during the assessment process OR you are identified as a risk to public safety for any other reason, your company may/will be informed and company policy will be followed. Please contact your Human Resources department regarding the company policy for additional details.

Worker's Compensation Claims: In accordance with company policy, if after a company-initiated referral the employee brings legal action of any kind (including a grievance or worker's compensation claim against his/her company) which makes the employee's mental or emotional condition or substance misuse an element of the claim, the EAP will release the employee's records to the company if requested to do so by the company.

Internal Operations of the EAP: From time to time, the EAP may need to review clients' confidential medical information for its internal operations, such as eligibility for the program, quality assurance/quality control, evaluating its LNAs, and for determining its cost basis or other internal operations that are necessary to meet its contractual and business obligations. To the extent practicable, the EAP will not disclose any confidential medical information that can be identified as belonging to a particular client, and will use the minimum necessary information in clients' records to complete the tasks required.

CONFIDENTIALITY

By signing this agreement, I understand that the EAP's Corporate Office and the LNA will be sharing confidential information regarding my participation in the EAP. I also understand that the EAP owns and will maintain the case record. With the exception of the above or listed below, The EAP and the LNAs will keep all confidential medical information relating to or about the client strictly confidential, except as described herein, allowed by law or in situations deemed potentially life threatening. Federal and state laws and regulations may also protect the confidentiality of each client's participation in this program. The violation of federal regulations is a crime and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a client's commission of a crime against the EAP property or personnel, or reports under state law of suspected child abuse or neglect. (See 42 U. S. C. 290dd-3 and 290ee-3 for federal laws and 42CFR Part 2 for federal regulations). Additional information regarding client confidentiality and rights may be found in the EAP Confidentiality Notice.

VOLUNTARY PARTICIPATION

Participation in the services offered by the EAP is voluntary. If you have a complaint, believe your rights to privacy have been violated or question about EAP services or the LNA, including questions relating to your confidential medical information, contact the EAP Workplace Services Supervisor at 1.800.935.9551. You may also contact the Department of Health and Human Services with any concerns about your rights to privacy.

TELEPHONIC FOLLOW-UP

I understand that I will receive a follow-up call from the EAP following completion of my EAP sessions. Please initial all that apply. I give permission for the LNA to call me at: Work \_\_\_\_\_ Home \_\_\_\_\_ I do not give permission for the LNA to call me for follow-up \_\_\_\_\_

I have read this form and I understand and agree to its contents. I have read and was given a copy of the EAP Confidentiality Notice.

Name of Client \_\_\_\_\_ Signature of Client/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

If you desire a copy of this Statement of Understanding, please inform the LNA.