OHIO EMPLOYEE ASSISTANCE PROGRAM

Helping and supporting you to be well and serve well…

Ohio Employee Assistance Program
Walk-In Service Form

(Confidential Personal Information)

Client Name (First) _____ (MI) ___ (Last): _____

Address: _____ City_____ Zip_____

Date of Birth ___\ ___\ _____

Home Phone (____) _____- _____ Work Phone (____) _____- _____ Gender _____

Marital Status _____

Why are you seeking services from the Ohio EAP?

Please place a check mark next to all that applies to your situation:

Alcohol use or abuse		Legal	
Other drug use or abuse		Marital / Relationship	
Emotional / Personal		Work Related	
Family		Health Concerns	
Financial		Other	

Have you visited OEAP before? Y ___ N___

If yes, when, please indicated month/year: _____

Additional Information that may be helpful:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) and Sec. 3701.041 of the Ohio Revised Code and HIPPA standards prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.