

Date: _____

Provider/Counselor Name

Address

City, State, Zip Code

Reference: Employee Name _____

Dear Treatment Provider / Counselor:

The above-referenced employee has agreed to enter into a Participation Agreement (PA) with the Ohio Employee Assistance Program (OEAP). The PA holds disciplinary action in abeyance while the employee is actively involved in treatment, which allows the employee an opportunity to resolve personal problems that may be impacting the employee's job performance.

Enclosed is a copy of the *Authorization for Release of Information* form, the following are instructions for completing the form:

- The release should be completed by the provider conducting the assessment, which would allow the assessor and the OEAP Case Consultant to exchange communications regarding the employee's status while in treatment.
- Please assist the employee in completing the Release of Information form to ensure it is signed, dated and returned to OEAP via fax at: (614) 728.3046 or email to: OEAP@das.ohio.gov.

Also, included is the *Participation Treatment Plan Outline*. This form must be completed by the assessment provider. It allows the assessment provider to provide a brief outline regarding the initial treatment plan.

Finally, immediately following the initial assessment, please mail or fax the completed forms to the assigned OEAP Case Consultant identified by the employee during the first session. The OEAP Case Consultant will contact you upon receipt of all forms to establish a process for reporting/updating OEAP on the employee's status (i.e., progress, compliance or non-compliance) with the established treatment plan.

If you have any questions or concerns, please contact the OEAP Case Consultant at 1-800-221-6327.

We appreciate your assistance.

Sincerely,

Ohio Employee Assistance Program Team

Participation Treatment Outline

Instructions: This form must be completed by the provider/counselor conducting the initial assessment and/or providing on-going treatment. Please complete the sections as indicated then fax to: (614) 728.3046 or email to: OEAP@das.ohio.gov.

Section A:

Please complete this section of the form *after the first appointment* with the client/employee and fax to OEAP at (614) 728.3046 or email to: OEAP@das.ohio.gov.

Client Name: _____

Provider Name: _____

Date of Initial Assessment: _____

Beginning Date of Treatment: _____

Treatment Plan Recommendations:

Residential Treatment: Y or N

Estimated Number of Days: _____

Estimated Discharge Date: _____

Intensive Outpatient Treatment: Y or N

Estimated Number of Days: _____

Estimated Discharge Date: _____

Outpatient Counseling: Y or N

Estimated Number of Sessions: _____

Frequency of Sessions:

Weekly

Bi-Weekly

Monthly

Section B:

Please complete this section *after the final appointment* with the employee and fax to OEAP at (614) 728.3046 or email to: OEAP@das.ohio.gov.

Date of Final Session: _____ Number of Sessions Attended: _____

Did the employee meet the treatment plan goals? Y or N (circle one) If no, please explain.

Explanation: _____

Provider's Signature: _____ **Date:** _____