

THE OHIO EAP PARTICIPATION AGREEMENT

Although referrals to the Ohio Employee Assistance Program are often more effective when discipline is not involved, it is sometimes necessary for discipline and the Ohio EAP involvement to occur simultaneously. This may happen even after a supervisor or union representative has repeatedly suggested the Ohio EAP to a troubled employee through non-disciplinary situations. The employee may have repeatedly rejected the suggestion and not remedied the job performance deficiency. When the employee reaches an advanced level of discipline, i.e., suspension or termination, either the employee or union representative may request that the employee and the agency enter into an **OHIO EAP Participation Agreement**.

The **OHIO EAP Participation Agreement** is a contract that states the work rule violation and the period of time the Agreement will be in effect (minimum duration of 180 days, maximum of 730 days). It conveys to the Ohio Employee Assistance Program the authority to develop a plan, agreed upon by the employee, to ensure the employee's participation in a recognized program of treatment as developed by a treatment provider. During the term of this Agreement, the employee agrees to refrain from further work rule violations and to comply with the terms of the Agreement.

During the period of the Agreement, management agrees to delay the contemplated discipline until the employee has an opportunity to fulfill the terms of the treatment plan. Upon successful completion of the program, the management will give serious consideration to modifying the contemplated disciplinary action. In direct relation to the employee's improvement in job performance during the period of the OHIO EAP Participation Agreement management may:

- Dismiss the contemplated disciplinary action.
- Modify or reduce the contemplated disciplinary action.
- Carry out the disciplinary action as originally proposed (If no improvement in job performance has been documented).
- Any employee who tests positive under random drug testing policy faces termination. If the employee successfully completes the agreement that termination is removed. If the employee is unsuccessful, or non-compliant, the termination is imposed.

The Ohio Employee Assistance Program agrees to serve as the OHIO EAP Participation Agreement monitor to ensure the employee meets all the terms of the treatment portion of the Agreement while management monitors the job performance aspects of the Agreement. Additionally, the OHIO EAP serves the role of communicating to the agreed-upon departmental or agency contact either the **compliance** or **noncompliance** of the employee with the terms of the agreement. Because of the often sensitive and confidential nature of the treatment involved, management will not be informed of any specific details of the treatment, only the fact of compliance or noncompliance.

Involvement in an OHIO EAP Participation Agreement cannot and should not be used as a refuge for inappropriate behavior. If the employee violates the terms of the Agreement and is found to be in noncompliance, then management has every right to carry out the discipline as originally contemplated.

Management Signature of Understanding

Date

Employee Signature of Understanding

Date

Union Signature of Understanding (Optional)

Date

**Procedure for Implementing the
OHIO EAP PARTICIPATION AGREEMENT
(Management, Union, Employee)**

Prior to signing the OHIO EAP Participation Agreement, the **designated MANAGEMENT REPRESENTATIVE (e.g., LRO, Human Resources)** will CALL the Ohio EAP and speak to an Intake Coordinator to facilitate the smooth implementation of the Agreement. This prior consultation will enable the Ohio EAP to provide better service to all parties of the Agreement. (Telephone Number: (614) 644-8545 or 1-800-221-6327).

MANAGEMENT REPRESENTATIVE RESPONSIBILITIES:

1. In order to be referred for services, instruct the employee to call a consulting Ohio EAP Case Monitor the same day that he or she signs the Agreement.
2. Forward a copy of the signed Ohio EAP Participation Agreement (minimum 180 day, maximum 730 day duration) and signed/completed Management and Union Representative Releases of Information to the EAP Case Monitor via fax machine (614/466-8745) or mail (if fax is not available) within the same day if possible. **See: management checklist. Management checklist to be signed and forwarded to the Ohio EAP.**
3. Provide the employee with the Treatment Provider cover letter, Release of Information forms and Participation Outline form (these are stapled) and instruct the employee to take these with him or her to the first counseling session. **These will be completed by the Treatment Provider and returned to the Ohio EAP consulting Intake Coordinator.**
4. Provide the employee with a copy of the Ohio EAP Participation Agreement and the signed Employee's Responsibilities handout.
5. The Management Representative will maintain contact with the Ohio EAP Case Monitor for verification of the employee's compliance or noncompliance with his or her treatment plan, as often as designated by the EAP Case Monitor consulting Intake Coordinator.
6. The same Management Representative will continue to monitor and document the employee's job performance and inform the EAP Case Monitor regarding any changes in the Ohio EAP Participation Agreement, job status, and/or behavior at the workplace.
7. If the agency is not able to secure compliance information from the Ohio EAP, the Management Representative will remind the employee of his or her responsibility of signing all necessary releases of information to enable the Ohio EAP to report compliance.

**OHIO EAP PARTICIPATION AGREEMENT
PROCEDURE**

UNION REPRESENTATIVE RESPONSIBILITIES:

1. Request that Management consider an Ohio EAP Participation Agreement at third or fourth level of disciplinary action, i.e., suspension or earlier when appropriate. This request is based on the fact that there is a bona fide personal problem affecting job performance.
2. Communicate all pertinent information such as disciplinary hearings or other concerns regarding the employee with the Ohio EAP Case Monitor. This will include termination of the Ohio EAP Participation Agreement and/or termination of employment, or behavior problems at the workplace.
3. Provide support, guidance and direction to the employee.
4. Be available to encourage employee to follow through with the Participation Agreement if the employee is not meeting the requirements. Communicate with the employee if expectations of the Participation Agreement are not being met.

**OHIO EAP PARTICIPATION AGREEMENT
PROCEDURE**

EMPLOYEE RESPONSIBILITIES:

1. Agrees to participate in a recognized program of treatment developed by a Treatment Provider to address a personal problem(s) affecting job performance. This includes keeping all appointments and following treatment recommendations.
 2. Call the OHIO EAP (614 / 644-8545 or 1-800-221-6327) on the same day of signing the Participation Agreement in order to be referred for services.
 3. Call the Treatment Provider to schedule an appointment as directed by the OHIO EAP.
 4. Take the Treatment Provider cover letter, release forms and participation outline form to the first session with the Treatment Provider/Counselor. These forms are to be completed by the Treatment Provider (releases signed by employee) and mailed/faxed by the Treatment Provider directly to OHIO EAP.
 5. Call and inform the OHIO EAP Case Monitor after having attended the first session.
 6. During the term of this Participation Agreement, the employee agrees to refrain from further work rule violations as defined in paragraph one, page six of the agreement and to comply with the terms of the Agreement.
 7. During the duration of the Participation Agreement, the employee will keep in touch with the OHIO EAP Case Monitor on a weekly basis until otherwise notified.
- * It is strongly suggested that even after the Participation Agreement is over, the employee continue to follow and comply with the Treatment Provider's recommendations and avoid further recurrences of the work rule violations/performance deficiency.

I, _____, have read, understood and received a copy of the "Employee Responsibilities" in an OHIO EAP Participation Agreement on _____.
date

MANAGEMENT CHECK LIST

To ensure accurate and timely monitoring of the OEAP Participation Agreement, the following information and procedures must be completed. Please complete all the forms in this packet. The OEAP Participation Agreement will become active when the OEAP receives the completed forms and gives confirmation that all the paperwork has been completed. The one exception to this procedure is the Provider/Counselor forms which need to be completed by the Provider during the employee's first visit, i.e., the AUTHORIZATION FOR RELEASE OF INFORMATION and the PARTICIPATION OUTLINE. The Provider/Counselor must fax or send these documents to the OEAP Case Monitor after they are signed and completed. Copies are kept by the Provider.

Please use this checklist to ensure that all forms are completed correctly.

- ___ **OEAP Participation Agreement Cover Letter (signed)**
- ___ **Employee Responsibilities (signed by employee) (page 4)**
- ___ **Completion of Employee Assistance Program Participation Agreement (page 6)**
- ___ Agency name (five designated places)
- ___ Description of job performance deficiency to be addressed, e.g., Tardiness, Absenteeism, Neglect of Duty, etc. Do not describe diagnosis or nature of the personal problem
- ___ Period of time to be in effect (the number of days: 180 day minimum, maximum 730 days)
- ___ Signatures of the employee, union representative, management representative, and witness
- ___ Dates of signatures
- ___ **Client Confidentiality Policy (signed by employee) (page 7)**
- ___ **RELEASE OF INFORMATION FORMS (completed)**
- ___ **Management Representative / Labor Relations Officer (page 8)**
- ___ PRINT names and complete mailing addresses
- ___ Signatures of the employee and the witness
- ___ Date of signatures, date of birth, and social security number
- ___ **Union Representative (page 9)**
- ___ PRINT names and complete mailing addresses
- ___ Signatures of the employee and the witness
- ___ Date of signatures, date of birth, and social security number
- ___ **Immediately fax all signatory documents (pages 1,4,5,6,7,8, and 9) to the OEAP Treatment Provider/Counselor (pages 10, 11, and 12) Stapled forms, given to the employee to take to the first session or to be completed if the provider name is known**
- ___ **Authorization for Release of Information (Page 11)**
- ___ PRINT names, addresses, and telephone number
- ___ Signatures of the employee and the witness
- ___ Date of signatures, date of birth, and social security number
- ___ **Participation Outline (Page 12) To be completed by the provider and, after the first appointment, to be mailed or faxed to the OEAP Consultant.**

Prior to mailing or faxing the above materials, copies are to be made for the employee, management, and union personnel. These materials should be kept in a safe, secure place and reviewed only by the persons designated on the release forms per State of Ohio and federal law.

If there are any questions, please contact an OEAP Intake Coordinator at **614 / 644-8545 or 1-800-221-6327. Fax: 614/564-2510.**

Management Signature of Understanding

Date

EMPLOYEE ASSISTANCE PROGRAM PARTICIPATON AGREEMENT

The Ohio Department of _____ and the employee agree to enter into a contract wherein
(agency)
the employee voluntarily agrees to seek assistance from a Health Care Provider under the Ohio Employee Assistance Program (Ohio
E.A.P.), to deal with the problem of _____.
(work rule violation)

The employee agrees to participate in a plan for a period of ____days (minimum or 180 days, maximum of 730 days). Said plan will
be developed by the Health Care Provider. The employee agrees to meet all of the requirements set forth in that plan. The employee
also agrees to verification as to whether or not the employee is keeping scheduled appointments and is in compliance with the agreed
to plan. Said verification will be made by the EAP Case Monitor assigned in accordance with the employee’s health plan contract.

A Participation Outline, including the lengths of the various aspects of service and the frequency of appointments or treatment
sessions, shall be submitted to the Ohio Employee Assistance Program as soon as possible, but not later than thirty (30) days from the
date of signing.

If the agency is unable to secure information from the EAP Case Monitor, it shall be the employee’s responsibility to provide the
employer representative with such information.

The employee further agrees to participate in follow-up care as recommended and/or required by the Health Care Provider, and agrees
that such follow-up care is to be verified to _____ by the EAP Case Monitor.
(agency)

_____ agrees that, so long as this contract is complied with in its entirety, the discipline
(agency)
_____ (indicate level of discipline)

recommended for this employee pursuant to the letter dated _____ shall be held in abeyance. Should the
employee violate this contract, in any part, the recommended disciplinary procedure will be implemented.

The employee understands and agrees that further occurrences of the problem described in paragraph 1, may result in the immediate
implementation of the proposed discipline.

By signing this agreement, the employee and Union agree to waive any contractual time restrictions regarding the imposition of
discipline.

The employee by signing this contract acknowledges that s/he has received a copy of this contract, and has been fully informed of the
terms and consequences of it, and hereby voluntarily enters into said contract after having been advised by his/her representative, if
applicable.

_____ further agrees that if the employee successfully completes the agreed to plan as
(agency)
certified by the Ohio E.A.P. or its designee, _____ will review the proposed discipline and
(agency)
seriously consider modification of the discipline imposed.

Employee Signature

Appointing Authority or Designee

Date

Date

Union Representative (Optional)

Witness

Date

Date

OHIO EMPLOYEE ASSISTANCE PROGRAM

CLIENT CONFIDENTIALITY POLICY

A. In accordance with Ohio Revised Code 3701.041, Federal Regulations (42 CFR part 1), and HIPPA standards, any information that you provide to the Ohio Employee Assistance Program (OHIO EAP) will not be disclosed without your signed authorization or consent, except under the following circumstances:

1. To medical personnel to the extent necessary to meet a medical emergency
2. Reported or suspected physical abuse, sexual abuse, and/or neglect of children which is required by Ohio law to be reported to a county's child protective agency protective agency (e.g., Franklin County Children Services)
3. Reported or suspected physical abuse, sexual abuse, neglect, and/or exploitation of an aged adult (i.e. sixty years or older) which is required by Ohio law to be reported to a county's department of human services agency (e.g., Franklin County Human Services Department)
4. Potential harm, danger or threat of death to oneself or another person, which is required by Ohio law to be reported to public law enforcement authorities and/or intended victims
5. The Ohio EAP provides compliance or non-compliance information to employers and unions in cases where the employee and employer enter into an Ohio EAP Participation Agreement or voluntary agreement. When appropriate, it may be necessary to share this information when conducting or arranging legal services, preparing for, or testifying at arbitration hearings or other legal proceedings. Section 3701.041 of the Ohio Revised Code states that your information may be disclosed if authorized by an appropriate order of a court of competent jurisdiction granted after showing good cause.

B. In OHIO EAP Participation Agreement cases, the only information provided to your supervisor, management, agency, or institution (with your signed authorization specifying who is to be informed) will be that:

1. You are or are not participating in The OHIO EAP;
2. You are or are not meeting your scheduled appointments;
3. You are or are not in compliance with your action/treatment plan.

Any additional information will be provided only if you so specify in writing.

I have read and understand The OHIO EAP Client Confidentiality Policy.

Signature

_____/_____/_____
Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, of _____
(Name of Client/Participant) (Client's Address)

authorize **THE OHIO EMPLOYEE ASSISTANCE PROGRAM** to disclose to

Management Representative: Primary _____
(Name of Person)

Secondary _____
(Name of Person)

Primary _____
(Complete mailing address including Zip code) (Phone Number)

Secondary _____
(Complete mailing address including Zip code) (Phone Number)

the following information: **EMPLOYEE PARTICIPATION IN THE OHIO EAP.**

This disclosure is made for the following reason (s): TO DETERMINE CONTINUED EAP PARTICIPATION AND BACK UP DOCUMENTATION OF THE EFFORT TO SUSPEND DISCIPLINE WHILE SEEKING ASSISTANCE.

Specific information to be disclosed: VERIFICATION OF EMPLOYEE KEEPING SCHEDULED APPOINTMENTS, GENERAL MEASURE OF EMPLOYEE COMPLIANCE WITH RECOMMENDED COURSE(S) OF ACTION TOWARD RESOLVING PERSONAL ADJUSTMENT PROBLEMS CONTRIBUTING TO JOB PERFORMANCE PROBLEMS.

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) expires upon _____ or six months
from date of signature. (Date of PA expiration)

(Signature of Client/Participant) (Date)

(Date of Birth) (Social Security Number)

(Signature of Legal Guardian, if Applicable)

(Witness)

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.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, of _____
(Name of Client/Participant) (Client's Address)

authorize **THE OHIO EMPLOYEE ASSISTANCE PROGRAM** to disclose to

Union Representative: Primary _____
(Name of Person)

Secondary _____
(Name of Person)

Primary _____ (Complete mailing address including zip code) _____ (phone number)

Secondary _____ (Complete mailing address including zip code) _____ (phone number)

the following information: **EMPLOYEE PARTICIPATION IN THE OHIO EAP.**

This disclosure is made for the following reason (s) : TO DETERMINE CONTINUED EAP PARTICIPATION AND BACK UP DOCUMENTATION OF THE EFFORT TO SUSPEND DISCIPLINE WHILE SEEKING ASSISTANCE.

Specific information to be disclosed: VERIFICATION OF EMPLOYEE KEEPING SCHEDULED APPOINTMENTS, GENERAL MEASURE OF EMPLOYEE COMPLIANCE WITH RECOMMENDED COURSE(S) OF ACTION TOWARD RESOLVING PERSONAL ADJUSTMENT PROBLEMS CONTRIBUTING TO JOB PERFORMANCE PROBLEMS.

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) expires upon _____ or six months
from date of signature. (Date of PA expiration)

(Signature of Client/Participant) (Date)

(Date of Birth) (Social Security Number)

(Signature of Legal Guardian, if Applicable)

(Witness)

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.

Dear Treatment Provider / Counselor:

This employee has agreed to enter into an Ohio Employee Assistance Participation Agreement which holds disciplinary action in abeyance at his or her workplace while the employee is actively involved in treatment. This measure has been taken in an effort to allow the employee an opportunity (monitored by the Ohio EAP) to resolve any personal problems which are impacting on his or her work performance. Enclosed you will find two copies of the Authorization of Release of Information form. One form should be completed by the person conducting the assessment to allow him or her and the Ohio EAP Case Monitor to communicate regarding the employee's status in treatment. The other release should be completed for the provider/counselor who will be providing the on-going treatment if different from the assessment person. Please assist the employee in completing the release forms which must be signed, dated, and witnessed.

In addition, the assessment counselor should complete the Ohio EAP Participation Outline form, providing information on the initial treatment plan. This form is designed to be quick and easy to use. However, if your case notes include all the information requested on the Participation Outline form, then you may send a copy of your notes as a substitute. Immediately after the initial assessment is completed please mail or fax the completed forms to the assigned Ohio EAP Case Monitor identified by the employee at his or her first session.

The Ohio EAP Case Monitor will contact you when the forms are returned to establish a mechanism for reporting back to the Ohio EAP the employee's compliance or non-compliance with your established treatment plan.

Please feel free to contact the consulting Ohio EAP Case Monitor at 1-800-221-6327 if you have any questions or concerns. Thank you for your assistance.

Respectfully,

Ohio EAP Clinical Staff

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, of _____
(Name of Client/Participant) (Client's Address)

authorize **THE OHIO EMPLOYEE ASSISTANCE PROGRAM** to exchange with / obtain from

Treatment Provider: _____
(Name of Person) (Phone Number)

(Address) (City) (State) (Zip Code)

the following information: **FOCUS OF TREATMENT, PROGRESS IN TREATMENT**

This disclosure is made for the following reason (s) : TO HELP COORDINATE TREATMENT PLANNING AND TO MONITOR COMPLIANCE OR NON-COMPLIANCE WITH THE TREATMENT PLAN.

Specific information to be disclosed: **DIAGNOSIS, PROGNOSIS, PLAN OF TREATMENT, CLIENT'S COMPLIANCE WITH TREATMENT PLAN, AND ATTENDANCE AT SCHEDULED MEETINGS AND APPOINTMENTS.**

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) expires upon _____ or six months
from date of signature. (Date)

(Signature of Client/Participant) (Date)

(Date of Birth) (Social Security Number)

(Signature of Legal Guardian, if Applicable)

(Witness)

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.

PARTICIPATION OUTLINE

Please complete section A of this form after the first appointment with the client/employee and mail/fax to the Ohio Employee Assistance Program. Thank you.

Please complete section B of this form after the final appointment with the employee and mail/fax to the Ohio Employee Assistance Program. Thank you.

Section A

Client Name: _____

Provider Name: _____

Date of Initial Assessment: _____

Beginning Date of Ongoing Treatment: _____

Treatment Plan Recommendations:

Residential Treatment Estimated Number of Days _____
Y or N 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

Date of final session: _____ **Number of Sessions Attended** _____

Did the employee meet the treatment goals? Y or N (circle one)

Please explain:

Provider's signature: _____