Appendix 3. EAP Supervisory Referral Form
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STATE OF MARYLAND - EAP SUPERVISORY REFERRAL FORM

The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee who may have a personal problem that may negatively impact (or has negatively impacted) their job performance. Additionally, please note that the EAP contractor will inform the State's EAP Coordinator of each instance where an employee attends or fails to attend a scheduled EAP counseling session. **THIS FORM MUST BE SUBMITTED TO THE EAP COORDINATOR. IN THE SPACE PROVIDED PLEASE WRITE BRIEF A SYNOPSIS EXPLAINING THE BASIS FOR REFERRAL.**

Please print legibly in ink or type. REFERRAL DATE: _____

COMPLETE EMPLOYEE INFORMATION BELOW:

EMPLOYEE'S NAME: _____ W#: _____

GENDER ☐ FEMALE ☐ MALE ☐ NON-BINARY/THIRD GENDER ☐ PREFER TO SELF-DESCRIBE ☐ PREFER NOT TO SAY

HOME ADDRESS: _____
(Address, City, State, and Zip Code)

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

WORK EMAIL: _____ PERSONAL EMAIL: _____

CLASSIFICATION: _____ GRADE: _____

START DATE: _____ DATE OF BIRTH: _____ MARITAL STATUS: _____

DEPARTMENT/AGENCY NAME: _____
(Do not use acronyms)

WORK ADDRESS: _____
(Address, City, State and Zip Code)

WORK HOURS/SHIFT: _____ DAYS OFF: _____
(Use 12 hour clock - DO NOT use military time)

COMPLETE AGENCY CONTACT INFORMATION BELOW:

SELECT REFERRAL TYPE: ☐ **SUPERVISORY** ☐ **MANAGEMENT**

REFERRED BY: _____ PHONE: _____

TITLE: _____ FAX: _____

AGENCY EAP REPRESENTATIVE: _____ PHONE: _____

TITLE: _____ FAX: _____

AGENCY EAP REPRESENTATIVE EMAIL: _____

MAILING ADDRESS: _____

_____ _____
Agency EAP Representative (Print Name) Agency EAP Representative (Signature)

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REASON FOR REFERRAL

FORM COMPLETION STEPS

#1: Select referral type.
#2: Select each applicable subcategory as it relates to the requested referral type.
#3: Attach all supporting documentation and/or provide a synopsis that supports referral type and corresponding subcategories.

I. ☐ **SUBSTANCE ABUSE REFERRAL**

***VIOLATION OF GOVERNOR'S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE*: YES/NO (Check One)**

☐ Failed random drug test ☐ Alcohol related conviction ☐ Other

II. ☐ **MENTAL HEALTH REFERRAL**

ATTENDANCE *(Please place numbers where numbers are requested)*

_____ # of days absent in past 12 month

_____ # of extended lunches past six (6) months

_____ # of times late in past six (6) months

☐ Pattern (e.g., Mondays, Fridays, after paydays, before and after holidays). Please describe: _____

☐ Other

JOB PERFORMANCE (Please provide supporting documentation for any items checked below):

☐ Lower quality of work ☐ Erratic work patterns

☐ Decreased productivity ☐ Failure to meet schedules

☐ Increased errors ☐ Inability to concentrate

☐ Impaired judgment/memory ☐ Other

BEHAVIOR DEMONSTRATED WITH RESPECT TO JOB PERFORMANCE

☐ Avoids supervisors/coworkers ☐ Unusually sensitive to advice/constructive criticism

☐ Less communicative ☐ Unusually critical of supervisor/coworkers/employer

☐ Disregard for safety ☐ Frequent mood swings

☐ Loss of interest ☐ Other

DOMESTIC VIOLENCE

☐

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SYNOPSIS_____

_____

_____

_____

_____

_____

_____

Have the above issues been discussed with employee? Yes ☐ No ☐

Has employee been referred to State Medical Director? Yes ☐ No ☐

IF EMPLOYEE INTENDS TO PARTICIPATE, THIS REFERRAL CANNOT BE PROCESSED WITHOUT "YES" INDICATED BELOW AND THE EMPLOYEE'S SIGNATURE

I understand that my employer is referring me to the State Employee Assistance Program. I also understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have seen this referral and all documentation contained therein and that I consent to and authorize the EAP Contractor to release my attendance, or lack thereof, and/or my compliance with the EAP Contractor's recommendations, to the State EAP Coordinator, Contract Manager and DBM Employee Relations Officer for the sole purpose of auditing the EAP Contractor's performance. The types of information that may be disclosed for the purpose of auditing Contractor performance are as follows: number of sessions per supervisor referral, location of EAP counseling sessions, timeliness of appointment scheduling, gender of employees, age ranges, marital status, agency, city of EAP counselor, and referral outcome. I understand this consent becomes effective on the date I sign it and will continue in effect for the duration of the contract term between the State Employee Assistance Program and EAP Contractor, including any optional years and retention periods I understand I have the right to revoke this authorization at any time, by following the revocation procedures described in the Notice of Privacy Practices. I understand that I am entitled to receive a copy of this authorization upon request. I agree that a photocopy or facsimile copy of this signed form is as valid as an original signed copy. I understand that after this information is disclosed, federal law might not protect it, and the recipient may re-disclose it. I agree to release the above-named individual(s) or organization(s) and the EAP, the EAP counselor, and his/her designee from liability that may result from furnishing this information as authorized in this disclosure.

☐ **YES**, I will participate in the Employee Assistance Program ☐ **NO,** I will not participate in the Employee Assistance Program

Name of Health Insurance Carrier _____

_____

Employee Signature Date

Your agency EAP Representative will securely forward this form and all supporting documentation to:
eap**.dbm@maryland.gov or 410-333-7603 (fax)**

If you have questions, please contact the Employee Assistance Program at 410-767-5846 or 410-767-1314.

FAILURE TO LEGIBLY AND FULLY COMPLETE THIS FORM WILL RESULT IN APPOINTMENT DELAY.

STATE EAP COORDINATOR ONLY

URGENT: Yes ☐ **No** ☐ **DATE:**

COMMENTS: _____

PRINT NAME: _____ **SIGNATURE:** _____

MS 561 (Revised 11/08/21)