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 A BRIEF 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 (Circle 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 (Circle One)

Has employee been referred to State Medical Director? Yes/No (Circle One)

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

STATE EAP COORDINATOR ONLY

URGENT: Yes/No (Circle One) **DATE:** _____

COMMENTS: _____

PRINT NAME:_____**SIGNATURE:**_____