Family Service of the Chautauqua Region

Employee Assistance Program (EAP) — Mandated Referral Form
332 East Fourth Street, Jamestown, NY 14701
Phone: (716) 488-1971 Fax: (716) 483-6878 Email: familyservice@familyservicechq.org

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SECTION 1 — Referral Information

Date: _____

Company Name: _____

Phone: _____

Supervisor/Referring Party: _____ **Title:** _____

Company Contact(s) Authorized to Receive Status Reports:

(Only the individuals listed above will receive status updates.)

Who will schedule the appointment? ☐ Supervisor ☐ Employee

Employee Name: _____**Position:** _____

SECTION 2 — Reason for Referral

Presenting Concern or Incident Prompting Referral:

_____
_____
_____

Referral Objective / Employer's Expectation for EAP Involvement:

_____
_____

☐ Employee currently suspended ☐ Not suspended

Reason for concern (check all that apply):
☐ Job performance ☐ Attendance ☐ Behavior/attitude ☐ Drug use concern ☐ Alcohol use concern ☐ Other: _____

SECTION 3 — EAP Communication Policy

Family Service of the Chautauqua Region's Employee Assistance Program (EAP) maintains strict confidentiality in accordance with federal and state laws.
Unless the employee provides written authorization, our reports to the employer will be limited to:

- Whether or not the employee has made contact with the EAP
- Whether or not the employee is attending sessions and following through with recommendations
- General compliance status (e.g., "in progress," "completed," "non-compliant")

No clinical details, diagnosis, or treatment information will be disclosed without additional written consent from the employee.

SECTION 4 — Employee Consent for Limited Release of Information

Date: _____ **Expiration Date:** _____
(no more than 12 months from today)

Employee Name: _____

I hereby authorize my EAP provider, Family Service of the Chautauqua Region, to release and receive limited information regarding my attendance, cooperation, and compliance status to/from my employer for the purpose of confirming my participation in the mandated EAP referral.

Information to be released may include only:

- Dates of contact or attendance
- Confirmation of participation or non-participation
- Follow-through with EAP or recommended services

I understand that no diagnostic, medical, or therapeutic information will be shared without my additional written consent. I also understand that I may revoke this consent in writing at any time, except to the extent that information has already been released based on this authorization.

If this release involves alcohol or drug abuse treatment, I understand that the information disclosed is protected by federal confidentiality rules (42 CFR Part 2). These rules prohibit further disclosure of this information without my written consent, unless otherwise permitted by the regulations.

Employee Signature: _____ **Date:** _____

Referring Supervisor Signature: _____ **Date:** _____

Please fax this completed form, including the employee's signature, to:
(716) 483-6878, or mail to the address above.