

EMPLOYEE ASSISTANCE PROGRAM

SSM Health at Work Employee Assistance Program (EAP) services are provided to you and your family as an employee benefit. EAP and/or its affiliate provide assessment, short-term counseling, referral and follow-up services to you at no cost. In some cases, referrals to service providers outside of SSM Health at Work EAP or the affiliate may be recommended. Following through with these recommendations is the choice of the client. All clients will receive at least two options for referral if possible, outside of St. Agnes Hospital or the affiliate provider, and will be documented in the client file. Any expense for the recommended referral resources are the responsibility of the EAP client. These services may be covered under your health benefit plan; however, it is your responsibility to determine whether the services are covered.

CONFIDENTIALITY

SSM Health at Work EAP and/or its affiliate services are strictly voluntary and confidential within the limits specified by law. The EAP is required to report suspected child abuse/neglect to a designated social service agency, and may also choose to report elder abuse/neglect, and act to prevent possible threats of suicide or potentially lethal violence. The EAP may also inform your employer, if you may cause danger or harm to them. This may include alcohol misuse or drug use, especially if you are in a safety-sensitive position. Otherwise, no information will be released unless the client has given written permission and has signed a formal release of information.

May we send correspondence to your home? All mailings will have a return

address of: SSM Health..... Yes No

May we call you at work? Yes No

May we call you at home? St. Agnes Hospital will show up on caller ID..... Yes No

May we call your cell phone? Yes No

May we leave a message on your voicemail? Yes No
 Home Home
 Work Work
 Cell Cell

May we mail a short satisfaction survey to your home? Yes No

I have read this form and understand its contents.

Client Signature: _____

Date: _____

Witness: _____

Date: _____