River Oaks

Today's Date: _____

Employee Assistance Program

Registration Form

_____ _____ _____ ____/____/____ Male / Female

First Name Middle Name Last Name Date of Birth Gender-*Circle One*

Address: _____

House/Apt Number/Street City State Zip County

SSN: ___-___-___ Marital Status: _____ Primary or Preferred Language: _____

Home Phone: (____)_____ Cell Phone: (____)_____ highest education completed: _____

Race: ☐Black/African American ☐White/Caucasian ☐Alaskan Native ☐American Indian ☐Asian ☐Native Hawaiian/or other Pacific Islander ☐More than one race ☐Other

Ethnic Origin: ☐Not of Hispanic Origin ☐Puerto Rican ☐Cuban ☐Other Hispanic ☐Mexican/Mexican American ☐Other

Employment Status: ☐Full time ☐Part time ☐Unemployed/looking for work ☐Homemaker ☐Student ☐Retired ☐Disabled ☐Unemployed/Not looking for work ☐Not applicable (under age 16)

Choose one of the following: ☐I live alone ☐ I live with relatives/spouse ☐I live with non-related persons ☐ I live with a paid care provider

Number Living in Household: _____

Are you a Veteran? ☐Yes ☐No Choose one: ☐not hearing impaired ☐hearing impaired ☐deaf

Current Employer: _____

Person being seen today is: ☐employee ☐employee's spouse ☐retired employee ☐dependent ☐other, please specify_____

Who referred you to EAP? ☐Self ☐Family Member ☐Supervisor ☐Other, please specify _____

Are you the employee with EAP benefits? ❑ Yes ❑ No

If **no**, complete ALL of page 2 and the remainder of this form.

If **yes**, on page 2, skip "Employee Information, Section A", begin again at "Section B" and complete the remainder of the form.

Employee Information

Section A

Please answer the following questions about the **employee who has EAP benefits.**

Last Name _____ First Name _____ MI _____

SS# _____ ❑ Male ❑ Female

Section B

Company _____ Department _____

Occupation _____

Date of Hire _____

Employee Health Insurance:
- ____ BC/BS PMD
- ____ BC/BS Personal Choice
- ____ PEEHIP
- ____ Other, please specify _____

Job Shift:
- ____ Day
- ____ Evening
- ____ Night
- ____ Rotating
- ____ Other

Labor Grade/Job Category:
- ____ Management/Supervision
- ____ Professional
- ____ Technical
- ____ Other Support Staff

Employment Category:
- ____ Regular Full Time
- ____ Regular Part Time
- ____ Temp Full Time
- ____ Temp Part Time

Length of Service:
- ____ 2 years or less
- ____ 2 – 5 years
- ____ 6 – 10 years
- ____ 11 – 15 years
- ____ 16 – 24 years
- ____ 25 years +

Presenting Problem(s): please check all that apply

Individual/Family:
- ____ Marital
- ____ Separation/Divorce
- ____ Non-marital relationship
- ____ Parenting
- ____ Behavior of child
- ____ Financial
- ____ Extended family
- ____ Self-concept/Self-esteem
- ____ Medical/Physical
- ____ Other individual and/or family concerns

Emotional:
- ____ Anxiety
- ____ Stress
- ____ Depression
- ____ Grief
- ____ Other mental health concern

Job-related:
- ____ Work performance issues
- ____ Formal supervisory referral
- ____ Informal supervisory referral
- ____ Employee liaison
- ____ Other job concerns

Substance Abuse:
- ____ Alcohol
- ____ Other drugs

Who is the focus of today's session? (check all that apply):
- ____ Self
- ____ Spouse
- ____ Child
- ____ Family member
- ____ Other

In your opinion, has the *employee's* job performance been affected by the presenting problem(s)? ❑ Yes ❑ No

Instructions for Client Communication

Client Name (please print): _____

Name of Parent/Legal Guardian (if applicable): _____

Instructions: Checking "Yes" ***you authorize*** an EAP representative to confirm/reschedule your appointment and to contact you about other appointment-related issues at the specified location. By checking "No", ***you do not authorize*** contact at the specified location. Check "N/A" if you do not have the specified method of contact.

I give my permission for the EAP to call my home to speak to me.	❑ **Yes**	❑ **No**	❑ **N/A**
I give my permission for the EAP to leave a message on my answering system at home.	❑ **Yes**	❑ **No**	❑ **N/A**
I give my permission for the EAP to call me at work to speak to me.	❑ **Yes**	❑ **No**	❑ **N/A**
I give my permission for the EAP to leave a message on my answering service at work.	❑ **Yes**	❑ **No**	❑ **N/A**
I give my permission for the EAP to call my cell phone to speak to me.	❑ **Yes**	❑ **No**	❑ **N/A**
I give my permission for the EAP to leave a message on my cell phone.	❑ **Yes**	❑ **No**	❑ **N/A**
I give my permission for the EAP to send me an email.	❑ **Yes**	❑ **No**	❑ **N/A**
I give my permission for the EAP to send a follow-up letter to my mailing address.	❑ **Yes**	❑ **No**	

Home phone number _____ Work phone number _____

Cell phone number _____ Email address _____

The **BEST** way to get in touch with me is (***please circle ONE***): Home Work Cell Email

I understand that EAP will make every effort to reach me personally in the manner that I have authorized. If they cannot reach me personally, I understand that they will leave a message on my answering service/voicemail only if I have given permission for them to do so.

In case of an emergency, EAP may contact:

Name _____ Relationship _____

Telephone: Home (____)_____ Work (____)_____ Cell (____)_____

Note: If you are unable to keep your appointment at the scheduled day and time, please call 24 hours prior to the appointment to cancel/reschedule.

This authorization may be changed or canceled by you at any time by instruction to your EAP Specialist.

_____ _____

Client or Parent/Legal Guardian Signature Date

EAP Office Policies and Statement of Understanding

Services Provided. This is a free, short-term service provided to you and your dependents. If additional services are needed beyond the scope of this program, referrals to other service providers will be discussed with you.

Availability. The EAP staff is available for appointments Monday through Thursday from 8:30 a.m. until 7:00 p.m. and on Friday from 8:30 a.m. until 4:30 p.m. A staff person is on call to handle emergency situations 24 hours a day, seven days a week by calling 205-650-0576 and asking to speak with the on-call therapist.

Confidentiality/Release of Information. Information concerning the use of EAP services will not be given to persons outside of EAP *EXCEPT* as mandated by law or as described below, and will not be part of the employee's personnel file.

- **Self-referral.** If an employee or an employee's family member initiates the appointment, no information will be discussed or released without expressed written consent, except as set forth herein.
- **Supervisor Referrals.** If an employee is referred by a supervisor for work performance issues, the referring supervisor will be confidentially advised that the employee has or has not scheduled and/or kept his/her appointment. The EAP will attempt to notify the employee that the referring supervisor will be informed of a missed appointment. The EAP will not discuss the employee's personal problems with, or release any additional information to the supervisor or anyone else, except as required or permitted by law or set forth herein, without the expressed written consent of the employee.
- **Commission of Illegal Acts or Posing Harm to Self or Others.**
  - If the referrer or EAP staff believes that the client, another person, or property is at risk of harm due to past or intended behaviors of the client, or it appears that an illegal act or threat has been committed against EAP or the client's employing company, their staff, or on their premises, the EAP staff may disclose information to prevent harm or to protect against criminal acts.
  - If an employee discloses the use/abuse of alcohol and/or drugs that violate company policies and that could endanger the client, employees, or the company, the EAP staff may disclose this information if public safety is at risk.
  - If acts of abuse and/or neglect of a child, elder, disabled adult, or other custodial individual are disclosed, the EAP staff is required to report such as a part of the mandatory reporting law.
  - Suicidal/Homicidal thoughts, intent, or plan require immediate response and may require EAP staff to release necessary information to prevent harm to self or others; this also applies to any thoughts, intent, or plan to harm self or others.

A Dependent Child as the Primary Client. If a child is being seen at EAP, age-appropriate limited confidentiality will be maintained for the child. Parents or legal guardians will be provided appropriate information regarding the child, including the assessment, treatment plan, and progress being made.

I have read this Statement of Understanding and understand its contents. Should I have specific questions, I will address them with the EAP staff person with whom I talk.

Client or Parent/Legal
Guardian Signature _____ Date _____

EAP Staff Signature _____ Date _____