MERCY EMPLOYEE ASSISTANCE PROGRAM
STATEMENT OF UNDERSTANDING

The Employee Assistance Program (EAP) is provided by your employer without cost to you. The role of the EAP is to assist you in clarification of personal problems, to offer short term counseling as appropriate and if needed, to refer you to community resources for more intensive care. The EAP will monitor your care to ensure that your needs are being met effectively. Fees for services provided by professionals outside the EAP may be covered by your insurance. However, you are responsible for any costs that are not covered.

Should you need to cancel or reschedule an appointment we request 24 hour notice so that the time slot can be made available to another person.

CONFIDENTIALITY. The EAP is confidential and will not disclose information that you revealed to anyone outside the EAP except in the following circumstances (1) your consent in writing, (2) the law required disclosure including if anyone's life or safety is threatened and (3) insurance verifications/claims certification is required.

Your opinion of the EAP is important and MERCY EAP uses several means to get feedback from you including Satisfaction Reply Cards and Follow Up Phone Calls. Our purpose is to see if you are satisfied with your EAP services and to hear how we can be more helpful to you.

SUPERVISORY REFERRALS. The EAP **will not advise** your supervisor of your participation in the EAP unless you are referred by your supervisor because of a **work performance problem**. Should that be the case, the EAP will confidentially advise your supervisor that you are coming to the EAP and are or are not in compliance with a plan to resolve the problem. The EAP **will not discuss** the specifics of your personal problems with the supervisor unless you request this in writing.

VOLUNTARY PARTICIPATION. Participation in the EAP is solely at your discretion. In the event an employee is offered EAP services as a result of a documented unsatisfactory performance or behavior, refusal to accept or utilize the EAP is not in itself, cause for termination.

I certify that I am not on an un-approved leave of absence, suspended or terminated.

I have read this statement and understand its contents.

_____ _____

Printed Name Witness

_____ _____

Signature Date

I have received the Mercy Notice of Privacy Practices: _____

Patient or guardian signature

_____ _____

Patient Name (Please Print) Date