We can help.

- Confidential counseling
- Onsite crisis response
- Staff training programs
- Consultation services

WellSpan® Employee Assistance Program

Supervisory Referral Step-by-Step Process & Required Forms

1. Based upon documented employee job performance issue(s), the decision is made by management that a supervisory referral is needed.
2. Supervisor making referral consults with Human Resources (HR), stating intent for formal referral of employee to the EAP. We request HR to then contact WellSpan EAP Client Services via phone at 1-866-227-6527 to discuss the case and provide background information.
3. HR and supervisor meet with the employee to make the referral, sign referral form and informed consent form (supervisory referral forms can be downloaded from web pages at www.wellspaneap.org). HR will explain the EAP referral process and outline expectations for participation with the EAP to address unacceptable job performance issues. The EAP provides an opportunity for the employee to address job performance issues. Participation with the EAP is voluntary and does not mean an employee is immune from disciplinary actions if job performance issues continue while the employee is in treatment.
4. Before the employee calls WellSpan EAP to schedule their first EAP appointment, HR should fax the completed supervisory referral forms and any supporting documentation to WellSpan EAP Client Services at **(717) 851-4493**. If the supervisor needs additional space to describe the reason for the referral, he/she can attach an additional sheet of paper with the supporting documentation. The employee should be aware of all information being shared with the EAP.
5. The referred employee is encouraged to call WellSpan EAP Client Services directly (within 72 hours) at **1-866-227-6527** to provide all necessary demographic information and allow WellSpan EAP to make the referral to an appropriate provider location convenient for the employee. WellSpan EAP Client Services hours are M-F, 7:30am – 4:00pm, Eastern Standard Time.
6. Via phone, WellSpan EAP notifies primary or secondary contact person listed on referral forms of the employee's first scheduled appointment date. We also encourage you to place the responsibility on the employee for keeping you informed of their progress.
7. The *INFORMED CONSENT* IS NOT A FORMAL RELEASE of information, it only authorizes communication if the employee no-shows/cancels their first visit. The employee will be asked to sign a formal "release of information form" at their first appointment which authorizes continued follow-up with the primary/secondary contacts listed on the supervisory referral forms after each session.
8. Via phone within one business day of each scheduled appointment, WellSpan EAP will call the primary contact listed on release of information form to provide update regarding the employee's participation (attended, no-show, rescheduled, scheduled follow-up). A *"Client Status Report"* completed by counselor is marked "confidential", and mailed directly to primary contact person listed on release of information form.
9. **Supervisor and/or HR are also strongly encouraged to follow-up directly with the referred employee** for information regarding their attendance at EAP sessions.

P.O. Box 1827
York, PA 17405-1827
866.227.6527 Tel
717.851.4493 Fax
www.wellspaneap.org

WELLSPAN
Employee Assistance Program

Supervisory Referral Form

Dear WellSpan EAP Professional:

I have spoken with Mr./Ms. (employee's full name) _____ regarding the following job performance issues (please provide specific details and include any documentation you have regarding these issues): _____

_____

_____

_____

_____

The progressive discipline process is at the following stage: (Please check all that apply)

☐ verbal warning ☐ written warning ☐ final warning

☐ other _____

and I am suggesting that the employee seek help through the Employee Assistance Program for whatever problems may be contributing to the performance difficulties.

The employee understands that he/she will be requested to sign a consent for WellSpan EAP to speak with me so that we can work cooperatively. I am aware that information exchanged will be directly related to job performance or attendance at sessions.

I will notify you of any improvement, decline, or other change in job performance.

Mr./Ms. (employee's full name) _____ is aware that seeking help through the EAP does not guarantee employment. Instead, continued employment is based on job performance.

_____	_____	_____
Employer's Printed Name	Employer's Signature	Date
_____	_____	_____
Employee's Printed Name	Employee's Signature	Date

Information should be faxed to:
Client Services Representative
Fax #: (717) 851-4493

P.O. Box 1827
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WELLSPAN
Employee Assistance Program

Informed Consent

Please note: this form only authorizes the EAP to inform the designated employer contacts when the employee has scheduled their first EAP visit (or if the employee no-shows/cancels, we can share that information). The employee will be asked to sign a formal release of information form at the first visit for continued communication regarding attendance.

I hereby authorize WellSpan EAP to disclose information to:_____
(Primary Contact Name/Phone Number)

_____
(Secondary Contact Name/Phone Number)

from the records of:_____
(Employee's Name) (Social Security Number)

_____
(Home Address) (Home Telephone Number) (Date of Birth)

Information to be released: By my signature below, I recognize that the information to be released may include my attendance at EAP sessions used in addressing the reason for this referral, and recommendations that may be provided to me or my employer regarding this referral. Attendance at EAP sessions may include scheduled appointment dates and attendance at those sessions, missed appointments, etc. Recommendations may include, but is not limited to, suggestions made by my treatment provider regarding referral for treatment beyond EAP sessions, recommendations for follow-up drug/alcohol testing (if referral was made for substance use/abuse), and suggestions for my employer in assisting me with resolving the issue being addressed by this referral.

This information is being disclosed to the above person(s), organization or agency from records whose confidentiality may be protected by the Drug and Alcohol Abuse Control Act (Pennsylvania Law, Act 63) and/or the Mental Health Procedures Act (Pennsylvania P.L. 817) and/or Confidentiality of Alcohol and Drug Abuse Patient Record Regulations (Federal Public Law 93-282) or, in accordance with the state where you receive services. My signature below authorizes release of all such information by routine/express mail service or facsimile transaction.

I understand that I have no obligation whatsoever to disclose information from my record and understand that I may revoke this authorization at any time in writing, except to the extent that action based on this consent has been taken. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated.

This authorization shall expire 1 year from the date executed unless otherwise specified by the client (employee).

_____ _____
(Print Employee's full name) (Witness Signature) (Date)

_____
(Signature of Employee/Responsible party) (Date)

Note: This authorization will not be accepted unless it is completed in its entirety. A copy of the form will be accepted in Lieu of an original.