



# New Avenues, Inc. Employee Assistance Program Statement of Understanding

Employee Assistance Program · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925-5730 · Fax: (574) 271 – 5980

## Purpose of Statement of Understanding

The purpose of this Statement of Understanding is to explain how the Employee Assistance Program (EAP) works and to outline for you what can be expected from the program. This information is to help you better understand and use your EAP.

The Employee Assistance Program is a short term solution-oriented counseling program. It is based on your employer's desire to offer their employees and family members help in managing problems that may affect personal well being, work performance and/or family life.

## Your Responsibility

Your employer has paid for this program, it is important for you to respect this benefit and respect your Provider (Counselor) by attending the scheduled sessions. If you find a need to cancel an appointment, please call your Provider 24 hours ahead of time. The provider has the right exercise an option not to reschedule if one or more failed appointments have occurred without appropriate or reasonable notification,

## Fees

Brief counseling in the EAP is offered at no cost to the employee and immediate family members living in the employee's household, or children living with a custodial parent if the employee has consented for a dependant to use this service. Your employer has already paid for this service. If you or a family member needs specialized or additional help beyond the scope of the EAP, discuss this with your Provider. Services not covered by the EAP include psychological testing, psychiatry visits, intensive outpatient programs, extended counseling, classes, court reports, or inpatient treatment. While your insurance may defray some or all of the cost of the services provided outside of the EAP, you, the employee (or family member) are responsible for payment of these services. The employee or family member is also responsible for knowing if the insurance plan is in effect at the time of service and whether pre-authorization is required. Your Provider can help in attaining a referral from your insurance plan if pre-certification is required for services not included in the EAP.

## Privacy

New Avenues EAP will not give information about your using the EAP to anyone outside the EAP without your permission, unless we are required to by law. Your participation in the EAP is confidential, your employer will not receive your name or any information that would identify you unless you give us your written permission to do so or you chose to tell your employer yourself.

Your Provider is required by law to give you their own Notice of Privacy Practices.

## Supervisory Referral

If a supervisor refers you to the EAP after discussing your work performance, or as a result of a violation of a work policy, you will need to sign an Authorization Form for Consent to Release Information before we will give any information to your employer.

## Voluntary Participation

Using the EAP is voluntary and in most situations is based on your decision to seek counseling. It is the client's decision to use (or not to use) the services. In some cases, as noted above, your employer may ask you to participate in the EAP because of your work performance or related disciplinary action for violation of a work policy.

## Complaints or Compliments

If you wish to make a comment or complaint about any part of your EAP experience, the quality of services, or any other aspect of the EAP, you may call directly to the New Avenues EAP administrative offices at 574-232-2131 or 800-731-6501 or you may wish to speak to your company's Human Resource Department. If you have given us permission at the time of your initial call to New Avenues we will be sending a Client Satisfaction Survey to your home. This is another opportunity for you to give us your feedback about the services you received.

Please sign below indicating you have read, understand this statement and agree to the terms of the EAP. Your Provider can answer any questions concerning the statement you might have.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

***PLEASE GIVE THE CLIENT A COPY OF THIS FORM and RETAIN A COPY IN THE CLIENT FILE***