

**MONTGOMERY COUNTY PUBLIC SCHOOLS EMPLOYEE ASSISTANCE PROGRAM
STATEMENT OF UNDERSTANDING**

Program

The Employee Assistance Program (EAP) of Montgomery County Public Schools is a confidential, voluntary service made available to all employees and retirees and their family members.

Fees

Meetings with the EAP specialist are offered at no direct cost to the employee, retiree or family member (client). Should the EAP specialist refer the client to a resource in the community, it is the responsibility of the client to pay for those services. Health insurance coverage may defray some or all of those costs.

Confidentiality

Information concerning a client's use of the EAP will not be disclosed to anyone outside of the EAP without the written consent of the individual, except as required by law or as described below, and will not be made a part of the employee's personnel record:

- *Dangerous situations.* If EAP staff believe that the client presents a danger to him/herself or another individual, the EAP staff may disclose information to prevent harm. EAP staff is also required by law to report suspicion of child abuse or neglect as well as the neglect, abuse or exploitation of vulnerable adults.

- *DOT covered employees.* If an employee with a CDL, covered by the Department of Transportation drug and alcohol testing regulations, reveals information about his/her alcohol or other drug use that causes EAP staff to be concerned for the safety of others, the EAP will take steps to ensure that the employee is relieved of safety sensitive responsibilities while provided with the opportunity to participate in treatment. The EAP will make arrangements to have the employee temporarily assigned to a non-safety-sensitive position, at the same rate of pay, while participating in treatment. *(These arrangements do not pertain to those individuals who access EAP services after submitting a sample which tests positive for alcohol or other drugs).* The confidentiality of the employee will be protected to the best of EAP staff ability.

- *Social Media and Mobile Device Location Services.* Due to the importance of confidentiality and the rules and regulations governing EAP Providers, EAP employees are not allowed to accept requests from current or former clients on any social networking sites (Facebook, LinkedIn, etc.). Please be aware that when location services are enabled on your mobile devices other people may have access to your location possibly compromising your privacy and confidentiality. If you choose, location services on your mobile devices can be turned off by you.

- *Telemental Health Care Services* There are benefits and risks associated with the use of telemental health. Benefits include convenience and flexibility. The risks associated with telemental health include disruption of transmission by technology failures, interruption, breaches of confidentiality by unauthorized persons, and/or limited ability by MCPS EAP to respond to emergencies. All information disclosed within sessions will be kept confidential to the extent allowed by law which includes written records. This information is protected under the Privacy Act and may not be disclosed without my written permission, except where disclosure is permitted and/or required by law. On occasion, sessions via telephone may be necessary due to technology failure or other circumstances.

Voluntary Participation

Participation in the EAP is voluntary. Employment or advancement in MCPS is not affected by an employee's decision to use (or not to use) the services of the EAP (unless the employee has entered into an agreement with the Office of Human Resources and Development specifying EAP participation as a special condition of employment). MCPS evaluates an employee on the basis of job performance criteria only, and not on the use of the EAP.

I have read this **Statement of Understanding** and understand its contents.

(Printed Name)

(Signature of client)

(Date)

EMPLOYEE ASSISTANCE PROGRAM Confidential Information Questionnaire



Today's Date ____/____/____

Employee I.D. _____

Last Name _____

First Name _____

Employee Name (if different from your own) _____

Are you a previous client at the Employee Assistance Program (EAP)? Yes No

Home Address _____ City _____ State _____ Zip _____

Birthdate ____/____/____ Gender _____ Pronouns _____ Marital Status _____

Phone Numbers Home _____ - _____ - _____ Work _____ - _____ - _____ Cell _____ - _____ - _____

How would you prefer to be contacted by the EAP? (Check all that apply)

Home Work Cell Outlook Personal e-mail: _____

Who referred you to the EAP?

EAP Human Resources Union Self Supervisor

Commercial Driver's License (CDL) Yes No

How did you first find out about the EAP?

ADR Brochure Supervisor EAP website EAP Workshop
 PAR Consultant Family Member Human Resources Union
 EAP Literature Other MCPS Employee Other Source New Employee Orientation

Race _____

Please rate your current job performance (check one) Excellent Good Needs Improvement Poor

MCPS EMPLOYEE INFORMATION

Job Title _____ Work Location _____

Employment Full Time Part Time Temporary On Leave Retired Other _____

How have the concerns that brought you to EAP affected your work performance? (Check all that apply)

absenteeism safety relationship with students
 tardiness relationship with supervisor not at all
 quality relationship with other employees other _____

Date Hired by MCPS ____/____/____

Emergency Contact Name _____ Phone _____ - _____ - _____

Health Insurance Company _____

Union MCAAP MCB0A MCEA SEIU Local 500 None Other _____

Education (what is the highest degree or level of school you have completed? If currently enrolled, highest degree received)

College degree Graduate degree High school/GED Less than 12 years

The EAP sends a confidential Client Satisfaction Survey through the e-mail of your choice. The feedback you give is used to improve the quality of our services and is appreciated.

What is your preferred e-mail? Outlook Private e-mail _____

NOTE: If you prefer the survey be sent to your work site through the PONY, please check this box

continued

Please list all members of your household. Please also list children who may not be living at home:

Name	Relationship	Birthdate	Occupation/ Grade in School	Living at home?
		___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No
		___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No
		___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No
		___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No
		___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you drink alcohol? Yes No **IF YES**, please answer the following questions:

1. How often do you have a drink containing alcohol? (check one)

- Monthly or less 2-4 times per month 2-3 times per week 4 or more times per week

2. How many drinks containing alcohol do you have on a typical day of drinking? (check one)

- 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

3. How often do you have five or more drinks on one occasion? (check one)

- Never Less than once per month Once per month Once per week Daily or almost daily

Please check any of the following that have been a concern to you within the past 6 months:

- | | |
|--|---|
| <input type="checkbox"/> alcohol or drug use | <input type="checkbox"/> grief |
| <input type="checkbox"/> anger | <input type="checkbox"/> health issues |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> housing |
| <input type="checkbox"/> bullying | <input type="checkbox"/> legal concerns |
| <input type="checkbox"/> career issues | <input type="checkbox"/> other person's alcohol/drug use |
| <input type="checkbox"/> couples/marriage problems | <input type="checkbox"/> other persons' mental health problem |
| <input type="checkbox"/> depression | <input type="checkbox"/> relationship with coworker |
| <input type="checkbox"/> disability | <input type="checkbox"/> relationship with students |
| <input type="checkbox"/> eating disorder | <input type="checkbox"/> relationship with supervisor |
| <input type="checkbox"/> eldercare | <input type="checkbox"/> sex |
| <input type="checkbox"/> family problems | <input type="checkbox"/> sexual harassment |
| <input type="checkbox"/> family violence | <input type="checkbox"/> suicide |
| <input type="checkbox"/> financial problems | <input type="checkbox"/> trauma |
| <input type="checkbox"/> gambling | <input type="checkbox"/> workplace stress |
| <input type="checkbox"/> other _____ | |

Over the past 2 weeks, have you had thoughts of harming yourself or anyone else? Yes No

Please briefly describe the concerns or problems for which you seek assistance:
