EAP Affiliates and Staff: Please offer to read the following statement to EAP participants and discuss the content with them, providing any additional assistance required to review and understand this document particularly for individuals with special needs.

EMPLOYEE ASSISTANCE PROGRAM
EAP PARTICIPANT STATEMENT OF UNDERSTANDING

To Our EAP Participants:

Beacon Health Options, Inc. is pleased that you have decided to use your Employee Assistance Program ("EAP"). The EAP is a voluntary service available to eligible employees and family members. There are several things we want you to know before we begin discussing your reason for contacting the EAP.

Personal problems are sometimes very difficult to talk about. That is why confidentiality is extremely important to us. We take every precaution in protecting the confidentiality of your visit with us and we hope that you will do the same. A written and electronic record (date, time, nature of meeting) of your contacts with the EAP will be maintained in a secure manner. Access to the record will not be given to anyone outside of the EAP, except as required by law or as described below. To access your file, contact Beacon Health Options, Inc.

This provides an opportunity for you to discuss personal problems with us. We will help you with an assessment of your personal problems and then develop a plan of action with you. The plan of action may include a referral to an appropriate resource to help you resolve your problems. After the referral is made, we will follow up to be sure the referral is satisfactory. In the event that there is no referral, we will still develop an action plan with you.

Lawful release of records is permitted under the following conditions: if we learn about child, elder or disabled adult abuse or neglect, if you pose a threat of imminent danger to yourself or others, if we are required to present records to comply with a court order, to comply with other state and federal requirements, and if we learn about any emergency medical circumstances which require immediate medical attention.

To the extent possible, we want to ensure the counselor that you will be meeting with is a person with whom you are comfortable. For example, some people have a preference for a counselor of a particular gender, sexual orientation, ethnicity, or religion. If this is a concern, Beacon Health Options, Inc. would like to give you the opportunity to let us know so that we may attempt to arrange a referral to a counselor that is appropriate for you. Should you have any concerns or be dissatisfied with the EAP or your counselor, please contact Beacon Health Options, Inc.

There is no cost to you for any EAP services provided by Beacon Health Options, Inc. The Employee Assistance Program does not, however, cover the costs of therapy or community resources/treatment services to which you may be referred. We attempt to maintain up-to-date information on your health insurance coverage so that we can refer you to providers covered by your plan. However, it is your responsibility to verify that your insurance will cover the cost of such therapy or other treatment or resources.

I hereby acknowledge that I have read and understand this Statement of Understanding.

_____	_____ __	_____
Participant Name (Please Print)	Participant Signature	Date
_____	_____	_____
Personal Representative Name (Please Print)	Personal Representative Signature	Date

If you are signing this form <u>on behalf of someone other than yourself</u>, please enclose with this form proof of your authority to do so and attach written documentation (i.e. Guardianship Order, Custody Order, Court Order) as appropriate.