

# Managed Care Concepts

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## Management Referral Acknowledgment and Rehabilitation Agreement

Type of referral (please check one):

\_\_\_\_\_ Drug Free Workplace Program (DFWP)

\_\_\_\_\_ Formal Management Referral (FMR)

**Employer** \_\_\_\_\_

**Site Location** \_\_\_\_\_

**Employee** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Manager** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

I, \_\_\_\_\_, acknowledge that, I have been referred by “my employer” known as \_\_\_\_\_ to Managed Care Concepts for

(Please circle one)

- (1) Job performance issues
- (2) Have tested positive for drugs and/or alcohol
- (3) Have voluntarily come forward to admit a problem with drugs and/or alcohol, and agree to be assessed by the Employee Assistance Program (EAP).

I agree to contact the EAP no later than 4:00 p.m. ET on \_\_\_\_\_.

Pursuant to the rehabilitation provisions of “my employer’s” workplace policy, I agree to **precisely** follow the requirements set forth below, and understand that my failure to do so may result in further corrective action or dismissal.

1. If counseling, a psychiatric evaluation or a rehabilitative treatment program is recommended as a result of my EAP assessment, I will be responsible for undertaking and certifying successful completion of such a program at my own expense with or without insurance. \_\_\_\_\_ (Employee's Initial)
2. I will contact a counselor or treatment facility provided to me by an EAP case manager within 48 hours to schedule an assessment. I will contact the EAP with the appointment date and time and keep that appointment. I will return all calls from the EAP and my treatment provider(s) within 48 hours. Failure to do so will be considered non-compliance and may result in further corrective action or dismissal. \_\_\_\_\_ (Employee's Initial)
3. I agree to allow the EAP representatives to disclose information related to my work performance issues and/ or substance abuse history, and reason for referral, to all potential providers, including substance abuse treatment facilities or programs. I also agree to allow treatment providers or programs to communicate with the EAP representatives regarding progress of and compliance with any rehabilitative treatment or other program recommendations. \_\_\_\_\_ (Employee's Initial)

4. I agree to allow the Employee Assistance Program professionals to communicate with "my employer's" Human Resources representative(s) \_\_\_\_\_ (name) and/or the designated manager(s) \_\_\_\_\_ (name) regarding attendance and participation with any rehabilitative treatment or any other treatment recommendations. I understand that my refusal to sign this authorization would prevent disclosure. This authorization is effective two (2) years from the date shown below or until case is closed. I may revoke this consent at any time by giving written notice to the Employee Assistance Program. \_\_\_\_\_ (Employee's Initial)
  
5. I will, at all times, comply with all the requirements of the rehabilitative treatment or other program recommendations and show a "good faith" effort in making continued progress. I further understand that should I fail to make continued progress (continued progress is defined in the treatment plan developed by the Employee Assistance Program and/or treatment facility), I may be subject to further corrective action or dismissal. If I have been taken off of the job as a result of this situation and a "fitness for duty" is required in order for me to return to work, I understand that this should be forwarded to my Employee Assistance Program for final approval. \_\_\_\_\_ (Employee's Initial)
  
6. **(For Drug Free Workplace Program only)** As a condition of continued employment under this agreement, after returning to work, I agree to be randomly monitored for drug and/or alcohol use for up to two years or until case is closed. These measures are to ensure that I remain drug-free. I will fully participate and comply with the Relapse Prevention Program developed by the Employee Assistance Program. \_\_\_\_\_ (Employee's Initial)
  
7. As a condition of continued employment under this agreement, I will contact an EAP case manager before the 10<sup>th</sup> day of each month to provide an update until my case is closed. I will ensure that the EAP has my current phone number at all times. \_\_\_\_\_ (Employee's Initial)

Failure to follow these requirements will be deemed as non-compliance and may result in further corrective action or dismissal. Nothing in this agreement precludes "my employer" from acting upon any legitimate and nondiscriminatory performance related issues. I agree to abide by all of "my employer's" policies and procedures as outlined in the personnel policy manual and/or Employee Handbook.

If I have a repeat infraction of "my employer's" workplace policies after completing the prescribed rehabilitative treatment program and returning to work, I may be terminated from employment with "my Employer".

I have read this agreement, I understand it fully, and I have had an opportunity to ask questions. \_\_\_\_\_ (Employee's initial)

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
"My Employer's" Representative

\_\_\_\_\_  
(Date)