TREATMENT / REHABILITATION CHECK-IN FORM

The purpose of this form is to have the employee being referred by the Department of Administration's Employee Assistance Program (EAP) to check into a rehabilitation program from the Department of Mental Health and Substance Abuse (MHSA) or any treatment facility approved by MHSA to verify that the employee had made an appointment with a Substance Abuse Counselor within ***10 business days from the date of the EAP Referral date.***

PART A: EMPLOYEE INFORMATION (*To be completed by Department/Agency's EAP Representative)*

Employee's Name: _____ **Social Security Number**: XXX-XX _____

Position Title: _____ **Date of Birth**: _____

Department: _____ **Section:** _____

Mailing Address: _____

Designated Representative Name: _____

Designated Representative Signature: _____

Designated Representative Email: _____ **Telephone:** _____

EAP Referral Date: _____

PART B: Department of Mental Health & Substance Abuse (*To be completed by a Substance Abuse Counselor/Professional) **NOTE**: Employee must present form within **10 business days** from the EAP Referral date.*

Please complete the section below that is relevant to this referral.

Today's Date: _____ **Date of Initial Appointment**:_____

Substance Abuse Counselor Name: _____

Substance Abuse Counselor Signature:_____

Position Title: _____ **Email**:_____

PART C: (*To be completed by the Department of Administration – Drug-Free Workplace Coordinator / EAP Administrator)*

_____ Signature of DOA DFWP Coordinator / EAP Administrator	DFWP – EAP STAMP RECEIVED:

********** Please forward all documents in DUPLICATE to DOA **********