Supervisor Referral Instructions and Forms

When an employee is showing signs of reduced productivity, absenteeism, erratic behavior or workplace conflict, **AllOne Health** can help. We will work with the management team and the employee to address a workplace concern. For **AllOne Health** to be part of an effective solution, we will require information as to the nature of the problem and an understanding of how the problem has been addressed prior to our involvement.

Initial response to performance or behavior issue:

Manager/Supervisor Responsibility	Employee Responsibility
Observation and documentation	
Discuss concern with employee	Discuss situation with manager
Outline expectations	Understand expectations
Identify obstacles & address as appropriate	Identify obstacles & address as appropriate
Make suggested referral to EAP if appropriate	Call 800-521-3273 to learn how AllOne Health can help
Continue documentation and communication	Attempt to make requested change & communicate

The Management Consultation

If the employee performance or behavior does not improve despite efforts to address it as described above, call the Intake Department at 800-521-3273 for connection to your Account Manager or a counselor for a *management consultation.* This will allow us to gain an understanding of the situation and discuss ways AllOne Health can assist with the situation.

In a **Supervisory referral**, the employee grants written consent for **AllOne Health** to inform designated contact people about their participation in our program to address a performance or behavior concern. An **AllOne Health** counselor confidentially assesses the employee to identify barriers which may not be apparent to the organization. Follow-up counseling sessions or referrals to other AllOne Health services will provide the assistance necessary for the employee to overcome these barriers. The **AllOne Health** Clinical Manager will provide updates on the employee's progress and engage the designated contact person in becoming an active part of the solution.

Making a Supervisor Referral

1. **Choose the appropriate form for the situation.**
    a. **If the issue is *substance abuse*, use the form on page 2 and discard page 3.**
    b. **If the issue is *work performance or behavior*, use the form on page 3 and discard page 2.**
2. Complete the form entirely. All questions are vital in understanding the problem and expectations.
3. The employee's signature on the form confirms that they have read the form and serves as a first line release of information. Without the employee's signature, **AllOne Health** cannot communicate with the designated contact person about any interaction involving the employee.
4. Once the form is filled out in its entirety and sent to the HR Contact (Company Representative) on the form, HR will send to referral to AllOne Health via secure email. If you need to send additional pertinent documents along with this form, understand that this information will become part of the client's file in accordance with HIPAA guidelines. This means the client will have access to this information. Only send information that has already been shared with the employee.
5. Have the employee contact **Intake at 800-521-3273** (option 2 when prompted) to set up their first appointment by the deadline documented on the form. This allows **AllOne Health** to know when to notify the designated contact person in the event that the employee does not call.
6. **AllOne Health** will email the designated company contact after the employee calls to schedule their first session and again after the first session. The **AllOne Health** counselor will obtain a second release from the employee which will allow the AllOne Health Clinical Manager to report additional information to the designated company contact. The Clinical Manager will follow up with an email report.
7. The **AllOne Health** Clinical Manager will monitor the employee's progress. The designated contact will receive a written report at regular intervals by secure email.
8. Communication from the designated contact person is necessary in order for the counselor to understand whether the employee is making progress toward their performance/behavior expectations. A manager feedback form will be provided at the time of the liaison's first communication to the designated contact person.

ALLONE HEALTH

Substance Abuse Supervisor Referral Form *(skip to page 3 for Work Performance / Behavior)*

PHONE: 800-521-3273 (option 2)

The purpose of this referral is to assist in the compliance of policy and return to work.

Organization:		**Referral Date:**	
Employee Full Name:		**Employee Title:**	
Date of Birth:		**Employee Dept:**	
Home/Cell Phone:		**Email:**	
Home Address:			

Identify the reason for the substance abuse referral: *(Please check one)*

- ☐ Pre-Employment Positive Screen
- ☐ Employee Self-Disclosure
- ☐ Reasonable Suspicion Positive Screen
- ☐ Random Drug Testing Positive Screen
- ☐ Post Accident Positive Screen
- ☐ Return to Work Positive Screen
- ☐ Aftercare following DOT referral completion
- ☐ Refusal to test

Job Safety Status: *(Please check one)*

- ☐ Non-Safety Sensitive Position
- ☐ Safety Sensitive Position
- ☐ DOT (Governed under DOT regulations) *If this referral is based on a DOT violation, employee **cannot** sign below*

Attachments: *(Check all that apply)*

- ☐ Quantitative Results (required)
- ☐ Last Chance Agreement or Employer Policy
- ☐ Disciplinary Action
- ☐ Reasonable Suspicion Checklist

Return to Work Plan: *(Check all that apply)*

- ☐ Employee can return to work upon the ability to test negative on a drug screen.
- ☐ Employee can return to work ***while*** attending the primary program required by AllOne Health (*subject to Clinical Coordinator approval*).
- ☐ Employee needs to ***complete*** the primary program required by AllOne Health prior to returning to work.

Note that any recommended outside services will be the financial responsibility of the employee. For example, educational classes, treatment, testing, etc.

Additional Comments (if applicable):

Employee must call 800-521-3273 (choose option 2 when prompted) by date: / /	Employee ☐ can ☐ cannot attend first appointment during work hours.

Authorization for Release of Confidential Information

The above named employee authorizes **AllOne Health** to disclose to:

HR Contact Name:	Traci Mottice		
HR Contact Title:	Employee Resource Administrator		
Full Address:	1180 S. Main St., Akron, 44301		
Phone:	(330)926-2496	**Fax:**	(330)643-8625
Email:	tmottice@summitoh.net		

Additional Contact (if necessary):					
Name:	Lisa Yeager	**Title:**	Deputy Director	**Email:**	lyeager@summitoh.net

I consent and request AllOne Health to release to my employer confirmation of the following*:*

- ***That I called to schedule an appointment and the date scheduled***
- ***The appointment was/was not attended***
- ***A description of issues affecting my ability to attend counseling sessions.***

Purpose of this disclosure: Coordination of referral and communication between the employer and AllOne Health.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that this authorization is voluntary. I may revoke this authorization at any time by delivering such revocation in writing to **AllOne Health**. I further understand that **AllOne Health** may not condition treatment on my signing this Authorization. I hereby release **AllOne Health** from all legal responsibilities or liability that may arise from any use or disclosure of information made pursuant to this Authorization. This Authorization shall remain in effect for 90 days from the date signed, unless revoked earlier in writing. **I certify that I have read, understand and agree to this Authorization.**

_____ _____

Signature of Employee ***(if DOT, employee cannot sign)*** Date

_____ _____

Signature of Company Representative listed as contact in above box Date

PLEASE PROVIDE A COPY OF THIS FORM TO THE EMPLOYEE

Work Performance / Behavior Supervisor Referral Form

PHONE: 800-521-3273 (option 2)

Organization:		**Referral Date:**	
Employee Full Name:		**Employee Title:**	
Date of Birth:		**Employee Dept:**	
Home/Cell Phone:		**Email:**	
Home Address:			

Describe your concern regarding the employee's current work performance or behavior issues (attach additional sheets if needed):

Provide information regarding the event(s) that led to this referral (attach additional sheets if needed):

Define the expectations required of the employee to improve their work performance or behavior:

What are the consequences of the employee not following through with work performance or behavior expectations?

Has this been a recurring problem? ☐Yes ☐No *If yes, explain*:

Is this a Safety Sensitive Position? ☐Yes ☐No

Employee must call 800-521-3273 (choose option 2 when prompted) by date: / /	Employee ☐ can ☐ cannot attend first appointment during work hours.

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HR Contact Title:	Employee Resource Administrator		
Full Address:	1180 S. Main St., Akron 44301		
Phone:	(330)926-2496 **Email:**	**Fax:**	(330)643-8625
	tmottice@summitoh.net		
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Name:	Lisa Yeager	**Title:**	Deputy Director
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Signature of Employee Date

_____ _____

Signature of Company Representative listed as contact in above box Date

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