**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**File Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYEE ASSISSTANCE PROGRAM**

**Statement of Understanding**

HumanaCare offers assessment, short-term counselling and referral services to you, your spouse and your eligible dependents through its Employee Assistance Program (EAP). The number of counselling sessions you receive is determined by your counsellor according to your presenting problem and the counselling model purchased by your employer. The EAP will not advocate on your behalf in work-related matters, legal matters pertaining to labour law, or personal legal issues.

**Length of Counselling and Fees:**

* The services are provided at no cost to you or your family. Your employer has already paid for the services.
* The EAP provides short-term counselling. The specific number of hours needed may vary. Your EAP Counsellor will help you to identify those goals that can be met within a short-term model and those goals that may require lengthier support.
* The EAP does not provide long-term counselling. In the event that your goals are assessed by your EAP Counsellor as requiring lengthier support, your EAP Counsellor will assist you in connecting with resources or services in your community to best assist your needs. **IT IS YOUR RESPONSIBILITY TO PAY FOR SERVICES PROVIDED BY ANY PROFESSIONAL PERSON OR AGENCY OTHER THAN A HUMANACARE EAP COUNSELLOR.**

**Note:** Your benefit plan or national health insurance may cover some of the cost.

**The cornerstone of EAP is confidentiality.** We bring to your attention the Canadian Federal legislation known as Bill C-6 Personal Information and Electronic Documents Act (PIPEDA). The focus of this Act is to protect the privacy rights of individuals concerning the collection, use and disclosure of their personal information. We are committed to collecting, using, and disclosing your personal information responsibly. All EAP personnel who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate uses and protection of your information.

**All discussions with your counsellor or records of your use of the EAP are confidential and will not be shared with your employer, other family members, or any other person or organization outside the EAP Program except as outlined below:**

1. You consent in writing;
2. Required by law or in a situation that may be deemed as potentially life threatening by your EAP;
3. Required by law include situations involving child abuse or directed threats of violence against others or self;
4. If records get subpoenaed by the courts;
5. If you are working in a Safety Sensitive Position, this may also mean reporting any drug or alcohol concerns to a company representative to assist in reducing the risk of harm to yourself, your coworkers and public safety;
6. Your counsellor will disclose information and records to HumanaCare as needed for coordination of EAP services, quality assurance, or payment.

**Late Cancels/No Shows:** If you are unable to keep your appointment it is important that you give us a minimum of 24 hour’s notice. Failure to do so will result in the loss of a session.

**Satisfaction Survey.**  As part of quality assurance, I authorize HumanaCare (EAP) to contact me to survey my satisfaction with the services I received.

In no event will HumanaCare be liable for indirect, consequential, exemplary, incidental, special, punitive, or aggravated damages. The limitations on liability in this paragraph shall apply irrespective of the nature of the cause of action, demand or claim, including breach of contract (including fundamental breach), negligence, tort or any other legal theory. For greater certainty, in no event shall HumanaCare be liable in respect of any third-party claims.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand this form and accept it as the terms of

Print Name

my participation in the program.

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Client/Parent or Guardian Date

Signature

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Witness Name Witness Signature

(Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check here if copy given to client

Date