MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

MARTIN O'MALLEY
Governor

ANTHONY BROWN
Lieutenant Governor

T. ELOISE FOSTER
Secretary

DAVID C. ROMANS
Deputy Secretary

CONFIDENTIAL

December 9, 2008

[redacted]

Dear Mr. [redacted]

You were referred to the Employee Assistance Program (EAP) for being in violation of the Governor's Substance Abuse Policy. As a result of this violation, you are required to comply with all of the steps detailed in this letter and to participate in substance abuse treatment that is no less than six months in duration. Rather than being seen by an EAP counselor at this time, in compliance with the State's Substance Abuse Policy you must obtain the appropriate substance abuse treatment immediately by completing the following steps:

1. **Review the enclosed list** of all substance abuse facilities in the state of Maryland. The list is arranged by county and includes both in- and out-of-network facilities. Please note that if you choose to seek treatment at an out-of-network facility, your co-insurance will be higher than had you chosen an in-network facility. After reviewing the list, select a facility and call that facility to schedule an appointment for an initial substance abuse assessment.
2. **Once you have scheduled the appointment for assessment,** contact Shoshana Altintas, LCSW-C, Clinical Care Manager at APS Healthcare at 1-877-239-1458 extension 3155 to obtain authorization for the substance abuse assessment. You must schedule a substance abuse assessment as soon as possible and contact Shoshana with that appointment information within 10 business days from the receipt of this letter. If you fail to comply with this request, your employer will be informed that the EAP has no knowledge of your entry into a substance abuse program, and you would therefore be non-compliant with the EAP. You are reminded in particular, that if you are currently on a 15-day suspension you are expected to enroll in treatment before that 15-day window expires.
3. **While at your initial substance abuse assessment,** please ensure that the following steps are completed with the facility staff:

   * **Within 10 business days** from your receipt of this letter it is important that you also complete and sign the two enclosed release of information forms using the self-addressed envelope provided with this letter and return them to the EAP office at: State Employee Assistance Program, Maryland Department of Budget and Management, 301 West Preston Street, Room 607, Baltimore, Maryland 21201. These forms authorize the release, by the treatment facility and by your EAP (including APS Healthcare), of any information that may be required to verify your compliance with the Employee Assistance Program. Please make sure to specify in the boxed area on the form titled "Continuing Treatment Provider" the name, complete mailing address, and telephone number of the treatment facility, as well as the name of your assigned counselor there, who may also sign both release forms as a "witness". Your treatment provider may also require you to sign their release, allowing them to exchange information with the EAP.

EAP EMPLOYEE REFERRAL LETTER

[redacted]
December 9, 2008

* **Inform the facility** that they must contact Shoshana Altintas at APS Healthcare at 1-877-239-1458 extension 3155 to provide clinical information for pre-certification of any level of substance abuse treatment.
* **Additionally,** inform your counselor that the facility must provide the EAP and APS with monthly progress reports regarding your compliance with required treatment. Reports sent to the State EAP Coordinator may be mailed to the EAP at the same address listed above, or faxed to the EAP at 410-333-5004. This report must also be faxed on a monthly basis to Shoshana Altintas at 1-877-334-0546.

If you have any questions regarding this letter please contact Shoshana Altintas at APS Healthcare at 1-877-239-1458, extension 3155, or myself at 410-767-5846.

Sincerely,

James Fox
State EAP Coordinator
State Employee Assistance Program

CONFIDENTIAL

ANNAPOLIS AREA

First Step Recovery Center, Inc.
914 Forest Drive
Annapolis, MD 21403
410-269-1017
APS Facility Status – In-Network

Partners in Recovery
49 Old Solomons Island Road
Annapolis, MD 21401
410-266-3770
Website: http://www.sheppardpratt.org

Hope House
26 Marbury Drive
Crownsville, MD 21032
410-923-6700
Website: http://www.hopehouserecovery.com

BALTIMORE AREA

Universal Counseling Services Inc.
122 Weber Street, 1st Floor
Baltimore, MD 21202
410-752-5525
Website: http://www.universalcounseling.com
APS Group Status — In-Network

Recovery Network
16 South Calvert Street
Baltimore, MD 21202
410-576-9191
APS Facility Status — In-Network

Center for Addiction Medicine
827 Linden Avenue
Baltimore, MD 21201
410-225-8240
Website: http://www.camtreatment.com
APS Facility Status — Pending Credentialing

Glass Substance Abuse Programs Inc.
821 North Eutaw Street
Baltimore, MD 21201
410-225-9185
APS Facility Status — In-Network

Crossroads Centers
2100 North Charles Street
Baltimore, MD 21218
410-752-6505
APS Facility Status — In-Network

Man Alive Inc.
2117 Maryland Avenue
Baltimore, MD 21218
410-837-4292
APS Facility Status — In-Network

Maryland Treatment Centers
3243 Eastern Avenue
Baltimore, MD 21224
410-276-0153
APS Facility Status — In-Network

Bon Secours
2401 West Baltimore Street
Baltimore, MD 21223
410-945-7706
APS Facility Status — In-Network

Gaudenzia
4615 Park Heights Avenue
Baltimore, MD 21215
301-324-1201
Website: http://www.gaudenzia.org
APS Facility Status — In-Network

BETHESDA AREA

Suburban Hospital
8600 Old Georgetown Road
Bethesda, MD 20814
301-896-3100
APS Facility Status — In-Network

Kolmac Clinic
1003 Spring Street
Silver Spring, MD 20910
301-589-0255
Website: http://www.kolmac.com
APS Facility Status — In-Network

Disclaimer: Network Status subject to verification.

Website: http://www.calverthealth.org
APS Facility Status — In-Network

Anchor of Walden Sierra
30007 Business Center Drive
Charlotte Hall, MD 20622
301-997-1300
Website: http://www.waldensierra.org
APS Facility Status — Out-of-Network

QUEEN ANNE'S AREA

Publick House
114-A South Lynchburg Street
Chestertown, MD 21620
410-778-2616
Website:
http://www.kenthd.org/addictions_program.htm
APS Agency — In-Network

A F Whitsitt Center
300 Scheeler Road
Chestertown, MD 21620
410-778-6404
Website: http://www.dhmh.state.md.us
APS Facility Status — In-Network

Talbot County Addictions Program
301 Bay Street
Easton, MD 21601
410-819-5900
Website: http://ww.talbothealth.org
APS Facility Status — Out-of-Network

Salisbury Area

Peninsula Addiction Services
104 West Market Street
Salisbury, MD 21801
410-860-2673
APS Facility Status — In-Network

Hudson Health Services Inc.
1506 Harting Drive
Salisbury, MD 21802
410-219-9000
Website: http://www.hudsonhealth.org
APS Facility Status — In-Network

Warwick Manor
3680 Warwick Road
East New Market, MD 21631
410-943-8108
APS Facility Status — In-Network

Delmarva Family Resources
828 Airpax Road, Building B, Suite 300
Cambridge, MD 21613
410-334-6687
APS Facility Status — In-Network

Wicomico Behavioral Health
108 East Main Street
Salisbury, MD 21801
410-842-3784
Website: http://www.wicomicohealth.org
APS Group Status — Out-of-Network

St. Charles Area

Open Arms Inc.
2590 Business Park Court
Waldorf, MD 20601
301-645-5538
APS Group Status — Out-of-Network

Alcohol and Drug Recovery
2670 Crain Highway
Waldorf, MD 20601
301-932-9720
APS Group Status — Out-of-Network

Anchor of Walden Sierra
30007 Business Center Drive
Charlotte Hall, MD 20622
301-997-1300
Website: http://www.waldensierra.org
APS Facility Status — Out-of-Network

Washington, DC Area

Second Genesis Inc.
1318 Harvard Street, NW
Washington, DC 20009
202-222-0126
Website: http://www.secondgenesis.org
APS Facility Status — In-Network

STATE EMPLOYEE ASSISTANCE PROGRAM
AUTHORIZATION FORM FOR RELEASE OF RECORDS AND INFORMATION
(Management Referral)

I. IDENTIFICATION

This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee Name _____

Employee Date of Birth _____

Employee Social Security Number _____

II. DIRECTIONS FOR RELEASE OF INFORMATION

I authorize the individual or company identified below in Section II-a to release and/or use protected health information pertaining to me (the person listed in Section I), to the individual or company identified in Section II-b.

II-a. I authorize the obtaining of information from:

- State Employee Assistance Program (EAP)

II-b. I authorize the disclosure of information to:

- Supervisory referral source *(Specify by name and position)* _____
- Management referral source *(Specify by name and position)* _____
- Other *(Name or describe)* _____

II-c. Information to be released: I authorize the disclosure and/or use of information regarding my acceptance of the EAP referral, participation in and receipt of treatment or services in the EAP, and release from treatment or services, with the exclusion of any information that identifies or discloses the nature of the problem for which I have been referred for treatment, or the type of treatment/ service recommended or provided.

II-d. Purpose of release: I authorize the disclosure and/or use of employment purposes.

III. RIGHT TO REVOKE

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire either 90 days from the closing of my case by the EAP or one (1) year after the date on which the Authorization is signed, whichever occurs first. To revoke the Authorization, I understand I must contact the following in writing: State EAP Coordinator, Employee Assistance Program, 301 West Preston Street, Room 607, Baltimore, Maryland 21201, or via fax to 410-333-5004.

IV. AUTHORIZATION AND SIGNATURE

I authorize the release of my confidential protected health information, as described in my directions in Section II. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the disclosure is to be made to conform to my directions. I understand that the EAP may condition treatment or services, or the payment for treatment or services on my completion of this Authorization, because the referral and subsequent treatment are for employment purposes. The information that is used and/or disclosed pursuant to this Authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws limiting the use and/or disclosure of my confidential protected health information.

I _____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ Your Signature

_____ Date

_____ Signature of Witness

STATE EMPLOYEE ASSISTANCE PROGRAM
AUTHORIZATION FORM FOR RELEASE OF RECORDS AND INFORMATION
(Assessment Provider)

I. IDENTIFICATION

This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee Name _____

Employee Date of Birth _____

Employee Social Security Number _____

II. DIRECTIONS FOR RELEASE OF INFORMATION

I authorize the individual or company identified below in Section II-a to release and/or use protected health information pertaining to me (the person listed in Section I), to the individual or company identified in Section II-b.

II-a. I authorize the obtaining of information from:

- (Specify EAP Assessment Provider) _____

II-b. I authorize the disclosure of information to:

- State Employee Assistance Program (EAP)
- Universal Counseling System (APS Healthcare EAP Representative)
- Other *(Name or describe)* _____

II-c. Information to be released: I authorize the disclosure and/or use of any information regarding my participation in and receipt of treatment or services in the EAP, including assessment/diagnostic date, and recommendations for treatment or services.

II-d. Purpose of release: I authorize the disclosure and/or use for the following reason(s):

(1) for employment purposes

(2) to make me eligible for service under the EAP

(3) to enable providers to bill any applicable health care providers or the EAP for the cost of my participation in the EAP.

III. RIGHT TO REVOKE

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire either 90 days from the closing of my case by the EAP or one (1) year after the date on which the Authorization is signed, whichever occurs first. To revoke the Authorization, I understand I must contact the following in writing: State EAP Coordinator, Employee Assistance Program, 301 West Preston Street, Room 607, Baltimore, Maryland 21201, or via fax to 410-333-5004.

IV. AUTHORIZATION AND SIGNATURE

I authorize the release of my confidential protected health information, as described in my directions in Section II. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the disclosure is to be made to conform to my directions. I understand that the EAP may condition treatment or services, or the payment for treatment or services on my completion of this Authorization, because the referral and subsequent treatment are for employment purposes. The information that is used and/or disclosed pursuant to this Authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws limiting the use and/or disclosure of my confidential protected health information.

I _____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ Your Signature

_____ Date

_____ Signature of Witness

STATE EMPLOYEE ASSISTANCE PROGRAM
AUTHORIZATION FORM FOR RELEASE OF RECORDS AND INFORMATION
(Continuing Treatment Provider)

I. IDENTIFICATION

This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee Name _____

Employee Date of Birth _____

Employee Social Security Number _____

Please complete information in this box, as designated)

II. DIRECTIONS FOR RELEASE OF INFORMATION

I authorize the individual or company identified below in Section II-a to release and/or use protected health information pertaining to me *(the person listed in Section I)*, to the individual or company identified in section II-b.

II-a. I authorize the obtaining of information from:

- State Employee Assistance Program (EAP)
- Universal Counseling Systems *(APS Healthcare EAP Representative)*
- Continuing Treatment *(Mental health or Substance Abuse. Specify provider name, mailing address, phone number, and name and telephone number of treatment counselor):* _____

_____

II-b. I authorize the disclosure of information to:

- State Employee Assistance Program (EAP)
- Universal Counseling Systems *(APS Healthcare EAP Representative)*
- Continuing Treatment Provider *(Specify Provider)*: _____

_____

II-c. Information to be released: This means, I authorize the disclosure and/or use of any information regarding my participation in and receipt of treatment or services in the EAP, including information pertaining to assessment, diagnosis, treatment and progress.

II-d. Purpose of release: I authorize the disclosure and/or use of the information for the following reason(s):

(1) for employment purposes
(2) to make me eligible for service under the EAP
(3) to enable providers to bill any applicable health care providers or the EAP for the cost of my participation in the EAP
(4) for continuity of care.

III. RIGHT TO REVOKE

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire either 90 days from the closing of my case by the EAP or one (1) year after the date on which the Authorization is signed, whichever occurs first. To revoke the Authorization, I understand I must contact the following in writing: State EAP Coordinator, Employee Assistance Program, 301 West Preston Street, Room 607, Baltimore, Maryland 21201, or via fax to 410-333-5004.

IV. AUTHORIZATION AND SIGNATURE

I authorize the release of my confidential protected health information, as described in my directions in Section II. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the disclosure is to be made to conform to my directions. I understand that the EAP may condition treatment or services, or the payment for treatment or services on my completion of this Authorization, because the referral and subsequent treatment are for employment purposes. The information that is used and/or disclosed pursuant to this Authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws limiting the use and/or disclosure of my confidential protected health information.

I _____, have read the content of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ Your Signature

_____ Date

_____ Signature of Witness