**Lake county, Florida**

**ATTACHMENT 2**

**EMPLOYEE ASSISTANCE PROGRAM Worksheet**

WORKSHEET INSTRUCTIONS: Answer the questions as completely as possible. **Do not** refer the reader to another section of your response.

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| **A. QUALIFICATIONS OF FIRM AND STAFF** |

1. Provide the following information about your company:

|  |  |
| --- | --- |
| Company Name |  |
| Service Center Location |  |
| Primary Contact for RFP |  |
| Contact Person Address |  |
| E-mail Address |  |
| Telephone |  |

2. List five (5) current client references of your Company. Public sector groups are preferred but not required.

| **Current Clients (1,000+ Subscribers)**  **Current Clients (Public Sector Groups Preferred)** | **Contact Name** | **Contact Title** | **Contact Telephone/ Email Address** | **Years as Client** |
| --- | --- | --- | --- | --- |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |

3. List the personnel your company will assign to help administer the EAP Program for each component below.

| **EAP** | **Name** | **Location** | **Years with Company** | **Current Work Load** |
| --- | --- | --- | --- | --- |
| Account Manager |  |  |  |  |
| Account Service Contact |  |  |  |  |
| EAP Clinical Contact |  |  |  |  |
| Trainer for Supervisors |  |  |  |  |

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| **B. EAP Administrative Services** |

1. Provide the following information regarding administrative services:

| Issue | Confirm | Deviations |
| --- | --- | --- |
| 1. Confirm that your Company will provide confidential and professional EAP services to benefits-eligible employees and their dependents with up to six (6) in-person sessions per issue for assessment, referral and short term counseling and up to three (3) fifty (50) minute telephonic Life Coaching sessions per issue. |  |  |
| 1. Confirm that your Company will provide EAP services that provide the following counseling and referral services:    1. Face to face counseling for, but not limited to:       1. Marital and Family Relationships       2. Stress Management       3. Alcohol and Drug Issues       4. Work-related Concerns       5. Depression and Anxiety       6. Bereavement       7. Work/Life Balance assistance    2. Life Coaching Services for, but not limited to:       1. Stress Management and Balance       2. Spirituality and Personal Growth       3. Career Planning and Developments       4. Motivation and Time Management       5. Finances and Budgeting       6. Legal Services | a. | a. |
| b. | b. |
| 1. Confirm that your Company will provide member tools and online services for obtaining EAP clinical and non-clinical information. |  |  |
| 1. Confirm that your Company will provide EAP telephonic customer service and urgent / crisis response counseling functions, which shall be available twenty-four (24) hours, seven (7) days a week and non-urgent visit within three (3) business days. |  |  |
| 1. Confirm that your Company will provide assistance to members in scheduling counseling sessions. The proposed process shall be timely, based on the member’s level of care needed and provider services requested. |  |  |
| 1. Confirm network will have sufficient availability to accommodate appointments. |  |  |
| 1. Confirm that your Company will provide referrals that integrate with behavioral health benefits offered through the County’s health plan. |  |  |
| 1. Confirm that your Company will record and maintain information regarding service-related or other complaints reported by covered participants. |  |  |
| 1. Confirm that your Company will provide the County with communication materials during the year to educate members and bring awareness to the EAP and Work Life services available. |  |  |
| 1. Confirm that your Company will provide an assigned account manager who shall be available to meet on a quarterly basis with the County and its administrative staff, or more frequently as deemed necessary by the County. |  |  |
| 1. Confirm that your Company will provide quarterly reports that include the following:    1. Employee satisfaction    2. Provider network retention    3. Quarterly and year-to-date services by assistance category to include breakdown by unique individual, number of EAP sessions utilized, work life utilization, online uses, services by provider (group, 1 to 1, telephonic), times from initial call to actual scheduled session, and results of additional services provided |  |  |
| 1. Confirm that your Company will provide an annual training session for all County supervisory personnel. |  |  |
| 1. Confirm that your Company will provide a minimum of Fifteen (15) hours of onsite EAP seminars for County employees annually to be used for trainings, orientation, etc. These can be virtual at the County’s discretion. |  |  |
| 1. Confirm that your Company will participate and attend the County’s Annual Benefits Open Enrollment sessions and Employee Health Screenings. Typically there is an average of five (5) Open Enrollment/Employee Health Screening sessions scheduled. These can be virtual at the County’s discretion. These meetings should not be included in the 15 hour onsite bank referenced in 13. |  |  |
| 1. Confirm that you Company will include the ability for self-referral and supervisor referrals. |  |  |
| 1. Confirm that your Company will provide consultation to Supervisors to assist them in resolving workplace issues and in making necessary referrals. |  |  |
| 1. Confirm that you Company will include Fitness for Duty exams for employees, if necessary to be billed separately. |  |  |
| 1. Confirm that you Company will include Substance Abuse Professional (SAP) services following DOT and Florida Drug- Free regulations to be billed separately. |  |  |
| 1. Confirm that your Company will provide unlimited on-site intervention incidents (e.g., Critical Incident Stress Debriefing or Emotional Incidence Stress Debriefing). |  |  |

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| C. Employee Assistance Program Provider Network |

* 1. List your Company’s number of EAP providers in your network having offices in each County. **Count a provider with multiple offices only once**.

| **County** | **LCSW** | **Psychologists** | **Psychiatrists** |
| --- | --- | --- | --- |
| Lake |  |  |  |
| Sumter |  |  |  |
| Marion |  |  |  |
| Volusia |  |  |  |
| Seminole |  |  |  |
| Orange |  |  |  |
| Osceola |  |  |  |
| Polk |  |  |  |
| **Total** |  |  |  |

* 1. List your Company’s number of EAP providers in your network who provide Fitness For Duty and DOT Substance Abuse Professional Evaluations in each County. **A provider with multiple offices may be listed more than once.**

| **County** | **Fitness for Duty**  **Level One** | **Fitness for Duty**  **Level Two** | **DOT-SAP**  **Evaluations** |
| --- | --- | --- | --- |
| Lake |  |  |  |
| Sumter |  |  |  |
| Marion |  |  |  |
| Volusia |  |  |  |
| Seminole |  |  |  |
| Orange |  |  |  |
| Osceola |  |  |  |
| Lake |  |  |  |
| **Total** |  |  |  |

Please respond to the following:

| Issue | Response |
| --- | --- |
| 1. Confirm that your Company will provide licensed, professional EAP counselors of varying degrees of professional licensing (certified psychiatrist, psychologist, family and marriage counselors) experience in providing EAP services. |  |
| 1. Confirm that your Company will provide comprehensive EAP National and Statewide provider networks. |  |
| 1. Confirm that your Company will provide access to quality licensed providers throughout the geographic boundaries of Lake County, and surrounding counties with high provider retention. Surrounding counties are comprised of Sumter, Marion, Volusia, Seminole, Orange, Osceola, and Polk Counties. |  |

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| **D. EAP Program Cost, MINIMUM EAP Services & Performance Guarantees** |

1. EAP fees are to be guaranteed for a minimum of three (3) years. Claims administration for incurred but not reported run out claims following termination of the contract are to be included in the proposed fees. Use the “All Eligible Employee” count to calculate the Per Employee per Month (PEPM) cost below.

|  |  |
| --- | --- |
|  |  |
| **Employee Breakdown** | **Employees** |
| **All Eligible Employees** | 1335 |

|  |  | **EAP Fees** | | | | |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Employees** | **2023-2024** | **2024-2025** | **2025-2026** | **2026-2027**  **Optional** | **2027-2028**  **Optional** |
| **All Eligible Employees**  **(Per Employee Per Month Fee)** | 1335 | **$** | **$** | **$** | **$** | **$** |
|  |  |  |  |  |  |  |
| **Total Annual Premium** |  | **$** | **$** | **$** | **$** | **$** |

* 1. **Please provide the following information.**

|  |  |
| --- | --- |
| **Issue** | **Response** |
| * + - 1. Confirm that the limit increase for years 4 and 5 shall not exceed 3%. |  |

1. Confirm the EAP Minimum Services included in your Company’s guaranteed EAP fees by checking YES below. List any additional fees for services that exceed the minimum services that are not included in your Company’s EAP fees in the column to the right.

| **EAP Minimum Services Included in EAP Fee** | **YES** | **NO** | **Additional Fees for Services Exceeding the Minimums** |
| --- | --- | --- | --- |
| 1. Confirm that program rates shall include the services outlined in the scope of services. |  |  |  |
| 1. Confirm that program rates shall be guaranteed for a minimum of three (3 years) |  |  |  |
| 1. Confirm that your Company will be responsible for all costs of producing, printing, and mailing/distributing adequate quantities of posters, brochures and flyers as designated by the County. The format and content of all materials used must be satisfactory to the County. |  |  |  |
| 1. Confirm that your Company will provide confidential and professional EAP services to Eligible Employees and their dependents (spouse, children and family members within their household) with up to six (6) sessions per issue for assessment, referral and short term counseling. |  |  |  |
| 1. Confirm that your Company will provide EAP services that will include the ability for self-referral and supervisor referrals. |  |  |  |
| 1. Confirm that your Company will provide EAP services that will include group counseling, telephonic and one to one counseling. |  |  |  |
| 1. Confirm that your Company will provide EAP telephonic customer service and urgent counseling functions that will be available 24 hours 7 days a week. |  |  |  |
| 1. Confirm that your Company will provide EAP services that will include counseling and referral services including but not limited to:    1. Work/Life Balance assistance    2. Coping with change    3. Child and elder care services    4. Eating disorders    5. Health and Wellness    6. Community resources    7. Psychological/Emotional problems    8. Marital/divorce issues    9. Anger    10. Domestic violence    11. Anxiety/Stress Management    12. Depression    13. Gambling addiction    14. Substance Abuse and Recovery    15. Financial Assistance    16. Legal Problems | a. | a. |  |
| b. | b. |  |
| c. | c. |  |
| d. | d. |  |
| e. | e. |  |
| f. | f. |  |
| g. | g. |  |
| h. | h. |  |
| i. | i. |  |
| j. | j. |  |
| k. | k. |  |
| l. | l. |  |
| m. | m. |  |
| n. | n. |  |
| o. | o. |  |
| p. | p. |  |
| 1. Unlimited Critical Incident assistance to the County. |  |  |  |
| 1. Confirm that your Company will provide EAP services that will include participation and attendance at the County's annual health fairs. |  |  |  |
| 1. Confirm that your Company will educational materials, including EAP brochures, instruction on accessing EAP, newsletters and posters to promote and encourage participation in EAP services. |  |  |  |
| 1. Confirm that your Company will effective educational materials and consumer web tools to assist employees and dependents with EAP related conditions including online EAP provider network. |  |  |  |
| 1. Confirm that your Company will provide participants with alternative options to EAP services as appropriate. |  |  |  |
| 1. Confirm program rates include claims administration for incurred but not reported run out visit charges following termination of the contract. |  |  |  |

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| --- | --- |
| **Question** | **Response** |
| 1. Describe the steps your company would take to resolve an access to care issue (i.e. a provider is unable to be assigned to a member in a timely manner). |  |
| 1. What is the average wait time for a coach, therapist, and/or psychiatrist? Provide the average wait time by month in the last 12 months. |  |

1. List any assumptions, limitations, or exclusions that are conditions of the EAP fees your Company is proposing. Indicate any impact to your proposed fees if any of these conditions are not met.

| **Assumptions, Limitations, or Exclusions** | **Impact** |
| --- | --- |
|  |  |
|  |  |
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|  |  |
|  |  |

1. List the **Performance Guarantees** your Company has included in your proposal.

| **Issue/Service** | **Performance Standard** | **Performance Guarantee** |
| --- | --- | --- |
| 1. Provider Network |  |  |
| 1. Customer Service |  |  |
| 1. Reporting |  |  |
| 1. Account Management |  |  |
| 1. Employee Satisfaction |  |  |

As an officer of the Company, I certify that the information contained in our proposal worksheet is accurate, and our Company will be bound by the contents of our proposal.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_