



**STATE OF MAINE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF LICENSING AND REGULATORY SERVICES**

**Behavioral Health Program  
Employee Assistance Program Application**

SECTION 1: Facility Information			
Facility/Agency Name:			
Physical Maine Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: (     )		Fax No.: (     )	
Email Address:		State Tax ID or Employer ID No.:	

SECTION 2: Fees	
APPLICATION FOR EMPLOYEE ASSISTANCE PROGRAM	
License Type: <input type="checkbox"/> New License (fee \$100) <input type="checkbox"/> Renewal License (fee \$50) <b>Total Fee Enclosed for application .....</b>	\$ _____
<b>Make check or money order payable to "Treasurer, State of Maine". Do not send Cash.          Credit Cards are not accepted at this time. Total Check/Money Order Enclosed: =</b>	<b>\$ _____</b>

*For questions regarding this program and/or application, please contact the following:*

Department of Health and Human Services  
 Licensing and Regulatory Services  
 Behavioral Health Program  
 41 Anthony Ave; 11 State House Station  
 Augusta, ME 04333-0011

Tel: (207) 287-4399      Fax: (207) 287-2671      Toll Free: 1-800-791-4080      TTY users call Maine relay 711  
 Email: [info.dhhs@maine.gov](mailto:info.dhhs@maine.gov)

Office Use Only:	
Check# _____ MO # _____	Amount \$ _____ Initials: _____ License# _____
Date Rec'd _____	Approved: <u>Yes</u> / <u>No</u> Effective Date: _____ Expiration Date: _____
Further Action Required: _____	
Disapproved (Reason): _____	
Notification to the Dept. of Labor: _____	
Date Certificate Sent and Number: _____	
Licensing Staff: _____	Date Review Completed: _____

<b>SECTION 3: Facility Contact Information</b>			
Name and Title of Primary Contact Person:			
Telephone No.: (     )	Email Address:		
Name and Title of Administrator/Operator:			
Telephone No.: (     )	Email Address:		
Name and Title of Executive Director:			
Telephone No.: (     )	Email Address:		
Corporation Name (if applicable):			
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: (     )	Fax No.: (     )		

<b>SECTION 4: Facility Information</b>			
Please complete the following information for the employees that are covered by your company's EAP in the State of Maine.			
Number of Employees: _____			
Age Range: _____			
Gender: _____			
<b>Type of facility:</b>			
<input type="checkbox"/> Individual Proprietorship	<input type="checkbox"/> Non-Profit Corporation	<input type="checkbox"/> Tribal Government	
<input type="checkbox"/> Church	<input type="checkbox"/> Partnership	<input type="checkbox"/> Parent Co-Op	
<input type="checkbox"/> Other (describe): _____			
<b>EAP Service Provider Information</b>			
Company Name:			
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: (     )	Fax No.: (     )		

<b>SECTION 5: Submission</b>
Remember to submit the following documents with your completed application: <ul style="list-style-type: none"> <li>• A check or money order made payable to "Treasurer, State of Maine"</li> <li>• Policy Manual (New applicants only)</li> <li>• Annual Report (Renewal applicants only)</li> <li>• Two (2) Year Re-evaluation EAP Utilization Report (Renewal applicants only)</li> </ul>

<b>SECTION 6: Declaration</b>						
I/We further certify that all information contained in this application is complete and accurate.						
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%; border-top: 1px solid black;">_____</td> <td style="width: 33%; border-top: 1px solid black;">_____</td> <td style="width: 33%; border-top: 1px solid black;">_____</td> </tr> <tr> <td><b>Print name of Applicant/Operator/Administrator</b></td> <td><b>Signature of Applicant/Operator/Administrator</b></td> <td><b>Date</b></td> </tr> </table>	_____	_____	_____	<b>Print name of Applicant/Operator/Administrator</b>	<b>Signature of Applicant/Operator/Administrator</b>	<b>Date</b>
_____	_____	_____				
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