



**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) - Current License # _____	Total Fee Enclosed for application \$ _____
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 \$ _____

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

Office Use Only:	
Check# _____	MO # _____
Date Rec'd _____	Amount \$ _____
Initials: _____	License# _____
Approved: <u>Yes</u> / No	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: _____

SECTION 3: Facility Contact Information			
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.: ())	

SECTION 4: Facility Information			
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: _____			
Type of facility:			
<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): _____			
EAP Service Provider Information			
Company Name:			
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: ())		Fax No.: ())	

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

SECTION 6: Declaration		
I/We further certify that all information contained in this application is complete and accurate.		
_____	_____	_____
Print name of Applicant/Operator/Administrator	Signature of Applicant/Operator/Administrator	Date