



Date

Employee Name  
Address

Dear \_\_\_\_\_:

We have been advised by your employer that you have been absent from work for more than 14 calendar days due to health reasons. We are sorry to hear that you are unable to work; however, we are pleased to advise that you are enrolled in the Community Social Services Early Intervention Program (CSSEIP). This program is being provided jointly by your union and your employer as part of your collective agreement. In order for us to appropriately assist you, the Healthcare Benefit Trust is coordinating the program and I will be your primary contact person. If you have any questions for your union, please contact your union representative, \_\_\_\_\_ (name) \_\_\_\_\_, at \_\_\_\_\_ (phone number) \_\_\_\_\_.

The purpose of CSSEIP is to provide proactive and timely services to employees who are ill or injured, and who need assistance in order to return to work. It is completely **confidential**, and your personal medical information is only provided to people who are part of your CSSEIP team, and only with your permission.

Our role is to ensure that you are getting the best healthcare management possible and, if appropriate, work in conjunction with our CSSEIP Medical Case Manager to co-ordinate your rehabilitation plan. The other people who may assist with your rehabilitation plan are your union, a representative of the Community Social Services Employers' Association (CSSEA), a rehabilitation consultant from the Healthcare Benefit Trust, your doctor, other medical professionals, and/or appropriate rehabilitation services. We will assist you with your recovery and return to work. Your employer will also play an important role in any return to work plans, but medical information will NOT be provided to your employer.

In order that we may monitor your progress and start gathering information for your rehabilitation plan (if appropriate), please do the following:

- Read and sign the authorization on the enclosed Occupational Fitness Assessment (OFA) form and take the OFA form to your doctor for his/her completion, as soon as possible. Your doctor can invoice the Healthcare Benefit Trust for the cost of completing the form, up to \$37.50 in accordance with the BCMA fee schedule.
- Return the authorization/OFA form (3 pages) to me within 7 days from the date of this letter. It can be faxed to me **in confidence** at 604-630-1475 or mailed to the address below. If you send the form to me by fax, the original also must be mailed to my attention. Your physician may choose to send the OFA form directly to our office.

By the time you receive this package, we may have spoken by telephone. If not, please call me as soon as possible at 604-630-1456 or toll free at 1-888-630-1456 ext. \_\_\_\_\_.

Yours truly,

Early Intervention Coordinator  
Community Social Services Early Intervention Program  
HEALTHCARE BENEFIT TRUST