Vertical Impaired Driver Rehabilitation Program-Evaluation Form

Please sign and complete highlighted areas only.

IDRP-Treatment Requirements for License Reinstatement

Please sign and date highlighted items only.

Impaired Driver Rehabilitation Program-Release of Confidential Information

If you have a significant other, an attorney or probation officer that will need information that you have completed the course please include them on this release.

If you received your offense in a different state, please include state, address and a fax number. *If you need to clear your license in another state or you live in another state you must complete the requested information. It is your responsibility to confirm that that the other state will accept VT's Impaired Driver Rehabilitation Program.*

If you are required to do counseling and have a counselor at this time, you will need to include their name and phone number if you wish for them to receive information you have completed this class.

<u>If you wish to attend the class, and we do not have your email address you will need to include it so that we may send you the zoom invitation.</u>

Sign and date please

Please complete all the questions on the DAST and the AUDIT

Please complete the Credit Card agreement form

Mail to NKHS/IDRP PO Box 368 St. Johnsbury, VT 05819

All intake paperwork and your payment of $400 must be returned by 10 days before the start date of the class you wish to attend. Please make your Money Order out NKHS. If you wish to pay by Credit or Debit card please call to make arrangements @ 802-748-3181 x1172. You must complete and return the Authorization to Charge Credit/Debit Card from.

Impaired Driving Rehabilitation Program
Northeast Kingdom Human Services
PO Box 368
St. Johnsbury, VT 05819
802-748-3181
802-473-4183 fax

DEPARTMENT OF HEALTH

Vermont Impaired Driver Rehabilitation Program

Evaluation Information

First Name:		Middle Initial:		Last Name:	
Date of Birth:		Phone:		VT PID:	
Address:					

Education Level:		Employment:	

Type of Offense	Date of Offense	BAC for Offense

By signing this form, I am attesting that all the information that I provided is true to the best of my knowledge and that I must complete the IDRP in it's entirety within five (5) years from today's date or will be required to start the Program over and pay all applicable fees.

Client Signature:		Date:	

Evaluation Information (To be completed by IDRP Evaluator)

Location of IDRP Evaluation:				Date of Evaluation:	
DAST Score:		AUDIT Score:		Offender Type:	
Approximate time since last use:		Alcohol:		Drugs:	

Clinician Comments:

Brief History of Substance Use:

Present Use:

Family History:

Additional Comments or Areas of Concern (including information about participation in IDRP Education Program):

Evaluator expectations for IDRP clinician:

Exit interview required? Yes No

By signing this form, I am attesting that all of the information that I provided is true to the best of my knowledge.

IDRP Evaluator Signature:		Date:	
License #:			

VERMONT
DEPARTMENT OF HEALTH
Impaired Driver Rehabilitation Program
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
Telephone: 802-651-1574
Fax: 866-272-7989

Impaired Driver Rehabilitation Program (IDRP) Treatment Requirements for License Reinstatement[1]

☐**First Offense Treatment Requirements:**
- Complete treatment with a licensed clinician (LICSW, LCMHC, LADC, LMFT, licensed psychologist), or a clinician with a master's degree who is actively pursuing licensure.
- The treatment must consist of a minimum of four (4) hours done over a minimum period of four (4) weeks. Depending upon treatment needs, the treatment requirements may be longer than the minimum.

☐**Multiple Offense Treatment Requirements:**
- Complete treatment with a licensed clinician (LICSW, LCMHC, LADC, LMFT, licensed psychologist), or a clinician with a master's degree who is actively pursuing licensure.
- The treatment must consist of a minimum of 20 hours done over a minimum period of 24 weeks. Depending upon treatment needs, the treatment requirements may be longer than the minimum.
- If the offense occurred after July 1, 2016, an ignition interlock device is required. Contact DMV for more information: (802) 828-2061.

☐**Life Suspension—Total Abstinence Application requirements:**
- For more information about applying for license reinstatement through the Total Abstinence process, please contact the Vermont Department of Motor Vehicles; Safety and Enforcement Unit at (802) 828-2000 or visit: http://dmv.vermont.gov/licenses/suspensions/total-abstinence.
- Complete treatment with a licensed clinician (LICSW, LCMHC, LADC, LMFT, licensed psychologist), or a clinician with a master's degree who is actively pursuing licensure.
- The treatment must consist of a minimum of 20 hours done over a minimum period of 24 weeks. Depending upon treatment needs, the treatment requirements may be longer than the minimum.
- An ignition interlock device is required for at least 3 years. Contact DMV for more information: (802) 828-2061.

➢ Treatment will not be considered complete until it has been approved by the counselor and, if required, the designated IDRP Evaluator. Progress may be measured through use of urine drug screens and/or other methods as requested by the IDRP Evaluator and/or counselor.

➢ If an exit interview is required, the participant must schedule it with the IDRP Evaluator. The Treatment Information Form must be received within 60 days of the final treatment session. If an exit interview is not required, the counselor must fax a completed IDRP Treatment Information Form to the IDRP Central Office. The IDRP Central Office fax number is: 1-866-272-7989. All forms can be found on the IDRP website at: healthvermont.gov/idrp.

➢ Once you have completed the Program, Vermont DMV will be notified of your completion within 12 business days. DMV typically processes licenses to be reinstated within three (3) business days.

➢ The IDRP must be completed within five (5) years or you will be required to start over and pay the required fees again.

➢ A participant may appeal the decision of the IDRP Evaluator or counselor in writing to the IDRP Director (Vermont Department of Health, P.O. Box 70, Burlington, VT 05401) or seek review of the decision in Superior Court pursuant to Rule 75 of the Vermont Rules of Civil Procedure.

_____ The above treatment information has been fully explained to me.

_____ I have been given a list of local counselors.

_____ I have been offered a list of local counselors and have declined it.

____________________________	____/____/______	________________________________	____/____/_____
Signature of Client	mm dd yyyy	Signature of IDRP Evaluator	mm dd yyyy

[1] Inpatient or residential treatment can be applied towards the IDRP treatment requirements. Participants must be successfully discharged (the client did not leave against medical advice or was administratively discharged) from the inpatient or residential facility with an aftercare plan. In these instances, the IDRP must receive the discharge summary and aftercare plan from the inpatient or residential treatment providers as well as the Treatment Information Form completed by the counselor providing treatment after inpatient or residential.

Revised 9/2021

These questions refer to the past 12 months.

Circle your response

1. Have you used drugs other than those required for medical reasons?................ Yes No
2. Have you abused prescription drugs? .... Yes No
3. Do you abuse more than one drug at a time? .... Yes No
4. Can you get through the week without using drugs? .... Yes No
5. Are you always able to stop using drugs when you want to?............................... Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use? .... Yes No
7. Do you ever feel bad or guilty about your drug use? .... Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs? .... Yes No
9. Has drug abuse created problems between you and your spouse or your parents? .... Yes No
10. Have you lost friends because of your use of drugs? .... Yes No
11. Have you neglected your family because of your use of drugs? .... Yes No
12. Have you been in trouble at work because of drug abuse? .... Yes No
13. Have you lost a job because of drug abuse? .... Yes No
14. Have you gotten into fights when under the influence of drugs? .... Yes No
15. Have you engaged in illegal activities in order to obtain drugs? .... Yes No
16. Have you been arrested for possession of illegal drugs? .... Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? .... Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?................................. Yes No
19. Have you gone to anyone for help for a drug problem? .... Yes No
20. Have you been involved in a treatment program specifically related to drug use? .... Yes No

Alcohol Use Disorders Identification Test (AUDIT)

Read questions as written. Record answers carefully. Begin the AUDIT by saying “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc. Code answers in terms of “standard drinks”. Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?
   (0) Never *[Skip to Qs 9-10]*
   (1) Monthly or less
   (2) 2-4 times a month
   (3) 2-3 times a week
   (4) 4 or more times a week
   ☐

2. How many standard drinks do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7 to 9
   (4) 10 or more
   ☐

3. How often do you have 6 or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   Skip to Q9 and 10 if Total Score for Q 2 and 3 = 0
   ☐

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   ☐

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   ☐

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   ☐

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   ☐

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   ☐

9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year
   ☐

10. Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year
   ☐

Record total of specific items here ☐

If total is greater than recommended cut-off, consult User’s Manual.

Scoring the AUDIT

Add scores together. Total score can be compared with the cut-off scores below to identify hazardous and harmful drinkers and alcohol dependence. A cut-off score of 8 or more indicates a hazardous or harmful pattern of alcohol consumption.

AUDIT Score	Risk Level
0 - 7	Low Risk.
8 – 15	Risky or hazardous level Moderate risk of harm
16 - 19	High-risk or harmful level
20 or more	High-risk Dependence likely

In addition to the total AUDIT score, a sub-total of ‘dependence’ can be calculated by adding the scores of **questions 4 to 6**. If this sub-total score is 4 or more, the patient is likely alcohol dependent and further assessment should be considered.

For more information and to access the guidelines see the World Health Organisation website:
http://www.who.int/substance_abuse/publications/alcohol/en/index.html

181 Crawford Road - Derby
PO Box 724, Newport, VT 05855

2225 Portland Street
PO Box 368, St. Johnsbury, VT 05819

nkhs.org

AUTHORIZATION TO CHARGE CREDIT/DEBIT CARD

NAME: ____

ADDRESS: ____

CITY: ____

STATE: ________________________________ ZIP CODE: ____________________

I AUTHORIZE NORTHEAST KINGDOM HUMAN SERVICES (NKHS) TO CHARGE MY CREDIT OR DEBIT CARD $400.00 FOR THE IMPAIRED DRIVING REHABILITATION PROGRAM (IDRP).

WE ACCEPT VISA AND MASTERCARD

☐ PAYING BY PHONE
CALL 802-748-3181
ASK TO SPEAK TO NKHS's IDRP REPRESENTATIVE

I WILL BE USING MY CARD ENDING IN (LAST 4 DIGITS OF CARD)__________CCV__________
THIS IS REQUIRED IF CALLING THE OFFICE WITH YOUR CARD NUMBER

☐ PAYING BY FORM
INCLUDE YOUR COMPLETE CARD NUMBER

____CCV____________EXP. DATE__________________

SIGNATURE: ____
TO PAY CREDIT CARD EITHER BY PHONE OR BY THIS FORM, YOU MUST RETURN THIS SIGNED FORM

OFFICE HOURS ARE MONDAY-FRIDAY 8:30-5:00

"THIS INFORMATION HAS BEED DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATION (42 CFR PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE."

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