NKHS
Northeast Kingdom Human Services

We're All About **Being Human!**

Vermont 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.

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.

Sign and date please

Please complete all the questions on the DAST and the AUDIT

Please complete the Credit Card agreement form

Please email to cwinsor@nkhs.net

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 pay by Credit or Debit card by completing the Authorization to Charge Credit/Debit Card form.

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

Vermont Impaired Driver Rehabilitation Program
Evaluation Information

March 2024

Client Information							
First Name:		Middle Initial:		Last Name:			
Date of Birth:		Phone:			VT PID:		
Address:			Email Address:				
Education Level:			Employment:				

Type of Offense	Date of Offense	Offense BAC

By signing this form, I attest all the information I provided is true to the best of my knowledge. I understand I must complete the IDRP in its entirety within five (5) years from this Evaluation date, or I will be required to restart the Program, including payment of all applicable fees.

Client Signature:		Date:	

Evaluation Information (To be completed by IDRP Evaluator)					
Location of Evaluation:				Date of Evaluation:	
DAST Score:		AUDIT Score:		Offender Type:	
Last use (approximate):		Alcohol:		Drugs:	

Evaluator Comments:

History of Substance Use (alcohol, cannabis, illicit substances):

Current Substance Use (alcohol, cannabis, illicit substances):

Family History:

Additional comments, areas of concern, Evaluator recommendations:

Treatment Required? Yes No

Evaluator expectations for IDRP treatment provider (i.e. goals/behaviors to address):

Exit interview required? Yes No

By signing this form, I attest all the information provided here is true to the best of my knowledge.

IDRP Evaluator Signature:		Date:	
License #:			
Supervisor Name & License # (*if applicable*):			

Impaired Driver Rehabilitation Program
Treatment Requirements for License Reinstatement

March 2024

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.
- Treatment must consist of a **minimum of 4 hours, over a minimum period of 4 weeks**. Depending upon treatment needs, the treatment requirements may be longer than the minimum.

Treatment Hours Required: _____ Number of weeks required: _____

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.
- Treatment must consist of a **minimum of 20 hours, 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 the DMV for more information: 802-828-2061.

Treatment Hours Required: _____ Number of weeks required: _____

Life Suspension—Total Abstinence 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.
- Treatment must consist of a **minimum of 20 hours, 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 the DMV for more information: 802-828-2061.

Treatment Hours Required: _____ Number of weeks required: _____

Phone: 802-651-1574 · Fax: 866-272-7989 · Email: AHS.VDHIDRP@vermont.gov
For more information, visit HealthVermont.gov/IDRP

VERMONT
DEPARTMENT OF HEALTH

Important Information

- Treatment will not be considered complete until it has been approved by the counselor and, if required, the 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.

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

- If an exit interview is required, you must schedule it with the IDRP Evaluator. The Treatment Information Form must be sent to IDRP Central Office within 60 days of the final treatment session. If an exit interview is not required, the counselor must send the completed Treatment Information Form to the IDRP Central Office.

    - Exit Interview ___ is ___is not required.

- Once you have completed IDRP, Vermont DMV will be notified of your completion within 10 business days. DMV typically processes reinstatements within 3 business days. IDRP Central Office does not have influence over DMV processing time. Questions about license reinstatement should be directed to the DMV.

- IDRP must be completed within five (5) years of starting or you will be required to start over and pay all fees again.

- You may appeal the decision of the IDRP Evaluator and/or IDRP Clinician via fax (1-866-272-7989), email (AHS.VDHIDRP@vermont.gov), or mail (IDRP, 280 State Drive NOB 2 North, Waterbury VT 05671-8340) or seek review of the decision in Superior Court pursuant to Rule75 of the Vermont Rules of Civil Procedure.

Participant Verification

___ The above information has been fully explained to me.

___ I have been given a list of IDRP counselors.

___ I have been offered a list of IDRP counselors and have declined it.

_____	_____	_____	_____
Participant Signature	Date	IDRP Evaluator Signature	Date

VERMONT
DEPARTMENT OF HEALTH

Impaired Driver Rehabilitation Program
Release of Confidential Information

December 2024

I, _____, with date of birth ____ /____ /____, authorize:

- The Impaired Driver Rehabilitation Program (IDRP),
- The Vermont Department of Motor Vehicles (DMV),
- Applicable Vermont District or Superior Court(s),
- The Vermont Department of Corrections, including Probation & Parole (if applicable),
- Court Diversion and/or Teen Alcohol Safety Program (if applicable)

to communicate with and disclose to one another information about the facts of my IDRP enrollment, status, and completion of the IDRP education/treatment program. The amount of information disclosed will be the minimum amount necessary to satisfy the purpose. This information may include substance use treatment information for the purpose of determining:

- Completion of requirements for the reinstatement of my driving privileges, and/or
- Compliance with the conditions of my probation/parole, and/or
- Other: _____

Please select any additional organizations or people to which IDRP may disclose or share information about your IDRP progress. This might include a spouse, family member, attorney, counselor, or another State's DMV. IDRP will not discuss your IDRP enrollment/completion with anyone or send proof of completion to another State without written authorization.

☐ Spouse/Family Member/Friend (must list name(s)): _____
_____

☐ Attorney (must list name): _____

☒ Counselor/Treatment Provider: NKHS _____

☐ Other person(s): _____

☐ Department(s) of Motor Vehicles outside Vermont:
State: _____
Address: _____
Fax/Email: _____

☒ I authorize the IDRP to communicate with me via email and understand that these communications cannot be guaranteed as secure or confidential.

Email address: _____

By signing this form, I understand: my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise allowed by the regulations. IDRP will protect my information but there is the potential for information disclosed pursuant to this consent to be redisclosed by the recipient. I may revoke this consent at any time by contacting IDRP except to the extent it was already relied on. If not sooner revoked this consent expires automatically upon my release from probation/parole and/or upon reinstatement of my driving privileges. I am not required to sign this form to participate in IDRP but if I do not sign this form IDRP cannot share program completion information with DMV or any other party.

Participant Signature: Date:

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.

NKHS
Northeast Kingdom Human Services
We're All About Being Human!

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 REHABILATION PROGRAM (IDRP).

WE ACCEPT VISA AND MASTERCARD

☐ 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."

Rev. 7/25