Community Care Network
Rutland Mental Health Services & Rutland Community Programs

Dear Participant

Rutland Mental Health Services/Community Care Network will be providing the IDRP Intensive Program utilizing Telehealth Services. Including Zoom, Doxy, & Adobe Sign.

You must provide us with a **current & valid email address** on the Release of Confidential Information *(located in this packet)* so we can provide you with the links to do the program. Along with the email you will need video chat capability on your smart phone, tablet or computer in order to proceed with the program.

Please download the Zoom App (*Zoom Cloud Meetings*) on your mobile device, tablet or computer. This free app that can be found at https://zoom.us.

We utilize Doxy for the initial intake with the program evaluator. Please visit our test link https://doxy.me/idrptest on your smart phone, tablet or computer to see if your device is compatible with Doxy. (Staff will not be monitoring the test link)

Once we receive your Paperwork and Payment back to the office we will contact you by email so please keep an eye on your email's Junk/Spam folder as some emails have been known to end up going there.

Please keep this page for your records.

IMPAIRED DRIVER REHABILITATION PROGRAM

2023 Intensive Program: White River Junction

Dates: Third weekend of each month.

Class: 49	January 21-22
Class: 50	February 18-19
Class: 51	March 18-19
Class: 52	April 15-16
Class: 53	May 20-21
Class: 54	June 17-18
Class: 55	July 15-16
Class: 56	August 19-20
Class: 57	September 16-17
Class: 58	October 21-22
Class: 59	November 18-19
Class: 60	December 16-17

Intake: By Appointment ***School Hours:*** Sat 9a-5p Sun 9a-1p

Location: Virtual via DOXY & ZOOM
(Links will be provided upon registration)

****This program is for people with a DUI 1 or DUI 2***
****People with three or more DUI's are not eligible.*** *

Fees: $400 for the IDRP Intensive Program. Payments must be made out to **R.M.H.S.** and must be received via **Money Order** or **Cashiers Check** before confirmation of admission to the program. **We do not accept Cash, Credit Cards or Personal Checks.** Cancellations prior to 24 hours will be refunded or applied to another school enrollment. There are no refunds for cancellations with less than 24 hours' notice.

Registration: To register for the program you must complete an enrollment packet which can be mailed to your home or downloaded at www.rmhsccn.org. The enrollment packet will contain the following: School Registration Form, Release of Confidential Information, Intake Questionnaire, Program Rules & Regulations, No-Show Agreement, Drug Questionnaire, & Alcohol Questionnaire. Once **all** paperwork has been completed and sent back to our office along with your payment you will be registered for the next available program.

Registration closes one week prior to the school date.

Submit via mail:
Community Care Network Substance Use Services
Attention: IDRP
98 Allen St. Rutland, VT 05701

Submit Paperwork by email: idrp@rmhsccn.org
Submit Paperwork by fax: 802-775-7196
(Payment must be mailed to office)

Please keep this page for your records.

IMPAIRED DRIVER REHABILITATION PROGRAM

School Registration Form

First Name: _____ Middle Initial: ___ Last Name: _____

Physical Address: _____

Telephone:(Home) _____ (Cell) _____

Date of Birth: _____

Number of Alcohol Related Driving Offenses: _____ State(s): _____

BAC Results: _____ License Number (if available) _____

Reason Attending this School: ☐ First DWI in Vermont ☐ Second DWI in Vermont

☐ Civil Suspension in state of _____

☐ Court/Probation ordered in state of _____

☐ DWI in another State: Date(s) _____
State(s) _____

☐ Other _____ in state of _____

Years of Education: _____ Current Student: ☐ Yes _____ ☐No

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Other _____

Employment Status: ☐ Unemployed ☐ Employed: ☐ Full Time ☐ Part Time

Employer: _____ Number of years _____

Any disabilities or accommodations that IDRP should be aware of? ☐ No ☐ Yes

If yes, Explain:

Signature: _____ Date: _____

Office Use Only

Date Fees Paid _____ School Location: _____ ☐ Intensive Program

School Class #: _____ Start Date: _____ ☐ Workbook Sent Given

Community Care Network Substance Use Services
98 Allen St. Rutland, VT 05701
Phone: (802) 747-3588 Fax: (802) 775-7196

VERMONT
DEPARTMENT OF HEALTH

Impaired Driver Rehabilitation Program
Release of Confidential Information

I, _____ , (with date of birth) _____ authorize:

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

to communicate with and disclose to one another information about the facts of my enrollment, current status, and completion of the IDRP School/therapy program. The amount of information disclosed will be the minimum amount necessary to satisfy the purpose. This information may include substance abuse 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 check any additional agencies/person(s) to whom information may be disclosed and received:

☐ Spouse and/or other family member (must list names) _____

☐ Attorney (must list name) _____

☐ Department(s) of Motor Vehicles in State(s) other than Vermont

State: _____

Address: _____

Fax: _____

☐ Counselor/Treatment facility _____

☐ Other person(s) _____

☐ 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.

Signature of Participant: _____ Date: _____

IMPAIRED DRIVER REHABILITATION PROGRAM

Intensive Intake Questionnaire

First Name: _____ Middle Initial: _____ Last: _____

Mailing Address: _____

Telephone:(Home) _____ (Cell) _____

Date of Birth: _____ License Number: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____ Alternate #: _____

Primary Care Physician: _____

Address: _____

Phone: _____ Preferred Hospital: _____

Have you ever been hospitalized? _____ Have you ever had a serious injury? _____

If yes, please explain: _____

_____

Do you have any medical problems (heart, diabetes, seizures, etc.)? _____

_____

Allergies: _____

_____

Please list current medications:

Medication	Doctor	Reason for taking	Will you be bringing with you to IDRP?
			□ Yes □No
			□ Yes □No
			□ Yes □No
			□ Yes □No
			□ Yes □No
			□ Yes □No

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IMPAIRED DRIVER REHABILITATION PROGRAM

Intensive Program Rules & Regulations

• Arrive promptly and attend all sessions; tardiness will result in dismissal from the program. An absence during a session will be considered voluntary withdrawal from the program and will result in being dismissed from the program.

• Attend the program alcohol and drug free. Any evidence of the use of substances prior to or during the program will result in immediate dismissal from the program. No alcohol / drug use while on lunch or any breaks. Breathalyzers &/or drug testing is random and mandatory.

• Active participation in session discussions will be required at all sessions and is must be appropriate. No foul language or inappropriate comments will be tolerated. Class leaders have final determination of appropriate behaviors. Inappropriateness or lack of participation may result in dismissal from the program.

• If any of the subject area or topics cause any stress or emotional response, please feel free to leave the room and return when possible. Please speak with group leaders on break about concerns or issues you may be having.

• Cell phones are to remain off or on silent during the programs. Cell phones are only allowed to be used while on breaks. Due to confidentiality no cell phone use is allowed in the rooms of the program.

• Behavior and clothing must be professional and appropriate. Do not wear any clothing that may be offensive including but not limited to; foul language, sexual themes or messages, clothing containing any alcohol or drug use, brands or logos. Inappropriate clothing is grounds for dismissal.

• Smoking follows hotel policy and if allowed must be in the designated areas.

• Emergency exits, and rest rooms will be pointed out by program leaders. If you need to use the rest room, please exit room quietly and return promptly.

• CONFIDENTIALITY is required and expected. This includes any people or discussions within the group.

• If an individual fails to successfully complete the IDRP Educational Program, no monies will be refunded. You may register into a second IDRP Program, at no additional cost. If you had paid for the optional meal you will need to repay the $15.00 to get another meal for the second program.

• Failure to satisfactorily complete a second IDRP Educational Program will require an additional program fee of $220.00

• Cancellation Policy: There is a 24-hour cancellation policy. If you cancel prior to 24 hours you will be able to have a full refund or have your payments applied to a different program. Cancellation after the 24-hour time will result in forfeiture of the fees paid.

I have read and agree to comply with all rules and regulations. I understand that any violation of program rules or inappropriate behavior (as deemed by program leaders) will result in dismissal from the program.

Client Signature _____ Date _____

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98 Allen St. Rutland, VT 05701
Phone: 802-747-3588 Fax: 802-775-7196

Community Care Network
Rutland Mental Health Services & Rutland Community Programs

IMPAIRED DRIVER REHABILITATION PROGRAM

NO-SHOW AGREEMENT

If you fail to show, are tardy for, or cancel, any IDRP appointment within 24 hours of your appointment time, you will be responsible to pay a $20.00 no-show fee. This fee must be paid in the form of a money order only. This should be payable to RMHS. This fee must be paid before you can reschedule your next appointment.

Print Name

Signature Date

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Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

☐ methamphetamines (speed, crystal)
☐ cannabis (marijuana, pot)
☐ inhalants (paint thinner, aerosol, glue)
☐ tranquilizers (valium)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+