ALL MULTIPLE DUI OFFENDER CLIENTS - PLEASE READ CAREFULLY

DUI offenders who get two or more DUI offenses within a five-year period are required, as a condition of license reinstatement, to get a clinical evaluation, and if indicated by the evaluation, complete a substance abuse treatment program. These requirements, effective July 1, 1997, are in addition to all other existing requirements for license reinstatement. Under this law, the Department of Human Resources (DHR) is responsible for approving clinical evaluators and treatment providers and establishing regulations for implementing these requirements.

DUI RISK REDUCTION PROGRAM

- You must complete the DUI Risk Reduction program before getting the clinical evaluation.

CLINICAL EVALUATION

- The clinical evaluation consists of a clinical interview, a review of your NEEDS or SALCE results from the DUI school, and any other assessment instruments deemed appropriate by the evaluator to complete a thorough evaluation. Only an approved evaluator from the DHR Registry of Clinical Evaluators can complete your clinical evaluation.
- You will be given a Clinical Evaluation Agreement / Contract that informs you of the services you are entitled to as part of the evaluation process.
- If the evaluation results in a treatment recommendation, the clinical evaluator must show you a list of approved providers (DHR Registry of Treatment Providers).
- The evaluator can only recommend a specific level of care.
- The evaluator cannot tell you to go to a specific treatment provider.
- The evaluator cannot determine the number of weeks you have to attend treatment.
- If the evaluator determines there is no need for treatment, the evaluator will submit a case presentation to DHR for review.
- If approved, DHR will provide the client with a “Requirements Met” form, which can be submitted to the Department of Motor Vehicle Safety (DMVS) for license reinstatement.

TREATMENT:

- You must choose a treatment provider from the DHR Registry of Treatment Providers who is permitted to deliver the ASAM level of care recommended by the clinical evaluator.
- NOTE: As part of a court order, only a judge can tell you to go to a particular treatment program. However, if a judge orders you to go to a treatment program not on the DHR Registry, completion of that treatment may not count toward driver’s license reinstatement.
- DHR requires that Level I services include three to nine hours of treatment services per week. The length of treatment is up to one year. A treatment review occurs when 17 consecutive weeks of has been completed. A decision will then be made for you to continue with more counseling or complete the treatment program.
- You will be given a Treatment Agreement / Contract that informs you all requirements for successful completion of the program.
- It is the responsibility of the treatment provider to determine the length of treatment and the number of hours you must attend. You may be expected to attend more than the minimum number of hours and weeks of treatment.
- The treatment program may have additional requirements to be met before you are considered as having completed treatment. Each individual treatment provider or agency determines additional services.
- Finally, you must have satisfied all fees to the treatment provider in order to receive your “Treatment Completion” form, which can be submitted to DMVS for license reinstatement.

Client Signature __________  Date __________
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
MULTIPLE DUI OFFENDER PROGRAM
Transfer of Clinical Evaluation to Treatment Provider

I, ____________________________, author

(Name of Client)

(Name of DHR Clinical Evaluator)

to disclose to the Georgia Department of Human Resources, Division of MH/MR/SA, Multiple Offender Treatment Provider the following information containing the results of my clinical evaluation as shown on the Multiple DUI Offender Case Presentation Form and any other necessary information about my DHR clinical evaluation. I am selecting the following DHR Treatment Provider:

(Name of DHR Treatment Provider)

The purpose of the disclosure authorized herein is to permit the transfer of my record to the DHR Treatment Provider of my choice.

I understand the transfer of my record can only take place by mailing or faxing a copy to the DHR Treatment Provider, and will be accomplished within five (5) business days of the signature of this release.

I also understand that only the Clinical Evaluation can be released. Re-disclosure of the SALCE/NEEDS Assessment is not permitted unless I authorize transfer. Please initial below:

☐ I authorize transfer of SALCE/NEEDS  ☐ I do not authorize transfer of SALCE/NEEDS

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Six) 6 months after the completion of my clinical evaluation or

(Expiration Date )

Client Signature ________________ Date ________________

Jan 1, 2003 (Rev.)
DUI INTERVENTION PROGRAM

ALL CLIENTS

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The purpose of the Risk Reduction Program is to help people who have experienced a problem because of their use of alcohol or other drugs. Your DUI, drug possession, or other charge may not be the first time you have had a problem because of your use of alcohol or drugs. The program will teach you how to reduce your chances of having future alcohol or drug related problems.

COMPLETION OF THE DUI, ALCOHOL OR DRUG RISK REDUCTION PROGRAM!

Some offenses that require completion of the DUI, Alcohol or Drug Risk Reduction Program (DUI SCHOOL) are DUI, Drug Possession, and Underage Alcohol Possession While Operating a Vehicle. Judges will sometimes order people to attend the Risk Reduction Program for other offenses. At the Risk Reduction Program you will take an assessment, and attend a 20-hour Intervention course. The results of your assessment are confidential, and will not appear on your driving record. You will learn about your assessment results during class. If you have questions, please talk to your Instructor after you begin class.

It is against the law for anyone to tell you that you have to attend a particular DUI Risk Reduction Program (DUI school). A Judge or Probation Officer may require you to bring proof that you completed the DUI School, but they cannot tell you which school you have to attend.

IF YOU HAVE RECEIVED 2 OR MORE DUIS IN THE PAST 10 YEARS

If you have a DUI arrest after 7-1-08, the law requires persons who have received 2 or more DUI in a ten-year period to get a substance abuse clinical evaluation and, if necessary, complete a treatment program in order to regain their drivers license. For arrests prior to 6-30-08, the period is five years.

IF YOU ARE FIRST TIME DUI OFFENDER

For DUI arrests after 7-1-08, all first DUI offenders are required to have a clinical evaluation and complete treatment if recommended as a standard condition of probation unless specifically waived by the judge for first offenders.

FOR ALL DUI'S

After you complete the Risk Reduction Program, you must get a clinical evaluation. This clinical evaluation is different from the assessment questionnaire you completed at the Risk Reduction Program. The Evaluator is a substance abuse professional who will interview you in person. He/she will have the results of your assessment survey from the DUI School to review before meeting with you. The Risk Reduction Program will provide you with the registry from the Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) listing all approved Evaluators in your area. You may choose any Evaluator on the registry.

After you choose an Evaluator, you will need to sign a Release of Information form and pay a $10.00 transfer fee, so that the Risk Reduction Program can send a copy of your assessment to the Evaluator. The costs for each Evaluator are listed on the registry, and start at $95.00. If the Evaluator offers reduced prices based on your income, that will be listed on the registry as sliding scale available. You will have to call or go to the Evaluator to see if you qualify for a reduced price. Some Risk Reduction Programs may have a Clinical Evaluator available, but you are not required to get your clinical evaluation at their facility.

After completing the clinical evaluation, the Evaluator may recommend that you attend a Treatment Program. The Clinical Evaluator will make a recommendation for the level of service you need and give you a DBHDD-approved registry of treatment providers in your area. The Evaluator and the Risk Reduction Program cannot refer you to a particular Treatment Provider; that is your responsibility. In addition, you cannot receive treatment services from the person who does your clinical evaluation. If you have someone in mind for treatment, do not select that person for your clinical evaluation.

NOTE: To be eligible for driver’s license reinstatement, you have to go to a Clinical Evaluator and Treatment Provider that are on the DBHDD-approved registry.

I have read the above information, or the program has read it to me. I have received a copy of this form.

__________________________________________  ___________
Student Signature                                  Date
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
MULTIPLE DUI OFFENDER PROGRAM

I, ______________________________________, authorize

(Name of Client)

________________________________________

(Name of DHR Clinical Evaluator)

to disclose to the Georgia Department of Human Resources, Division of MH/DD/AD the following information:

the results of my clinical evaluation as shown on the Multiple DUI Offender Case Presentation form and any other information about my evaluation necessary to determine an appropriate referral to or release from treatment.

The purpose of the disclosure authorized herein is to:

Enable the professional staff of the Department of Human Resources and its agents to review and approve the recommendation of my Clinical Evaluator.

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Six) 6 months after the completion of my clinical evaluation or ________________

(Expiration Date)

________________________________________

Client Signature

Date
EVALUATION CONTRACT

GEORGIA DEPARTMENT OF HUMAN RESOURCES
DUI CLINICAL EVALUATION PROGRAM

This contract specifies that ________________ agrees to receive an alcohol/drug evaluation from Price Counseling Center on ________________. This evaluation will be based on (1) conclusions drawn from the results of the SALCE test taken by you at the Risk Reduction center where you were seen on ________________, and (2) on a clinical interview, including a comprehensive history.

Based on the evaluation, a recommendation as to whether treatment is needed, will be made. This recommendation will also specify the level of treatment needed. It is your responsibility to choose a treatment provider, to follow up on getting into treatment if recommended, and to let us know the treatment provider of your choice.

Your evaluation will be forwarded to the treatment provider you choose, and notification of your evaluation will be sent to the Georgia Department of Human Resources. You must sign release of information consents for these purposes. All information about your evaluation will be held in confidence from any other notification.

The cost of this evaluation is $75.00 and is to be paid in full by cash or money order at the time of your evaluation. Your evaluation will be forwarded upon payment of the fee.

Client ____________________________ Date ________________ Witness ____________________________ Date ________________
<table>
<thead>
<tr>
<th>Question</th>
<th>Score Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have a drink containing alcohol</td>
<td>Score</td>
</tr>
<tr>
<td>Never (0)</td>
<td></td>
</tr>
<tr>
<td>Monthly or less (1)</td>
<td></td>
</tr>
<tr>
<td>Two to four times a month (2)</td>
<td></td>
</tr>
<tr>
<td>Two to three times a week (3)</td>
<td></td>
</tr>
<tr>
<td>Four or more times a week (4)</td>
<td></td>
</tr>
<tr>
<td>2. How many drinks containing alcohol do you have on a typical day</td>
<td>Score</td>
</tr>
<tr>
<td>1 or 2 (0)</td>
<td></td>
</tr>
<tr>
<td>3 or 4 (1)</td>
<td></td>
</tr>
<tr>
<td>5 or 6 (2)</td>
<td></td>
</tr>
<tr>
<td>7 or 9 (3)</td>
<td></td>
</tr>
<tr>
<td>10 or more (4)</td>
<td></td>
</tr>
<tr>
<td>3. How often do you have six or more drinks on one occasion?</td>
<td>Score</td>
</tr>
<tr>
<td>Never (0)</td>
<td></td>
</tr>
<tr>
<td>Less than monthly (1)</td>
<td></td>
</tr>
<tr>
<td>Monthly (2)</td>
<td></td>
</tr>
<tr>
<td>Weekly (3)</td>
<td></td>
</tr>
<tr>
<td>Daily or almost daily (4)</td>
<td></td>
</tr>
<tr>
<td>4. How often during the last year have you found that you were not</td>
<td>Score</td>
</tr>
<tr>
<td>able to stop drinking once you had started?</td>
<td></td>
</tr>
<tr>
<td>Never (0)</td>
<td></td>
</tr>
<tr>
<td>Less than monthly (1)</td>
<td></td>
</tr>
<tr>
<td>Monthly (2)</td>
<td></td>
</tr>
<tr>
<td>Weekly (3)</td>
<td></td>
</tr>
<tr>
<td>Daily or almost daily (4)</td>
<td></td>
</tr>
<tr>
<td>5. How often during the last year have you failed to do what was</td>
<td>Score</td>
</tr>
<tr>
<td>normally expected from you because of drinking?</td>
<td></td>
</tr>
<tr>
<td>Never (0)</td>
<td></td>
</tr>
<tr>
<td>Less than monthly (1)</td>
<td></td>
</tr>
<tr>
<td>Monthly (2)</td>
<td></td>
</tr>
<tr>
<td>Weekly (3)</td>
<td></td>
</tr>
<tr>
<td>Daily or almost daily (4)</td>
<td></td>
</tr>
<tr>
<td>6. How often during the last year have you needed a first drink in</td>
<td>Score</td>
</tr>
<tr>
<td>the morning to get yourself going after a heavy drinking</td>
<td></td>
</tr>
<tr>
<td>session?</td>
<td></td>
</tr>
<tr>
<td>Never (0)</td>
<td></td>
</tr>
<tr>
<td>Less than monthly (1)</td>
<td></td>
</tr>
<tr>
<td>Monthly (2)</td>
<td></td>
</tr>
<tr>
<td>Weekly (3)</td>
<td></td>
</tr>
<tr>
<td>Daily or almost daily (4)</td>
<td></td>
</tr>
<tr>
<td>7. How often during the last year have you had a feeling of guilt or</td>
<td>Score</td>
</tr>
<tr>
<td>remorse after drinking?</td>
<td></td>
</tr>
<tr>
<td>Never (0)</td>
<td></td>
</tr>
<tr>
<td>Less than monthly (1)</td>
<td></td>
</tr>
<tr>
<td>Monthly (2)</td>
<td></td>
</tr>
<tr>
<td>Weekly (3)</td>
<td></td>
</tr>
<tr>
<td>Daily or almost daily (4)</td>
<td></td>
</tr>
<tr>
<td>8. How often during the last year have you been unable to remember</td>
<td>Score</td>
</tr>
<tr>
<td>what happened the night before because you had been</td>
<td></td>
</tr>
<tr>
<td>drinking?</td>
<td></td>
</tr>
<tr>
<td>Never (0)</td>
<td></td>
</tr>
<tr>
<td>Less than monthly (1)</td>
<td></td>
</tr>
<tr>
<td>Monthly (2)</td>
<td></td>
</tr>
<tr>
<td>Weekly (3)</td>
<td></td>
</tr>
<tr>
<td>Daily or almost daily (4)</td>
<td></td>
</tr>
<tr>
<td>9. Have you or someone else been injured as a result of your drinking?</td>
<td>Score</td>
</tr>
<tr>
<td>Yes, but not in the last year (2)</td>
<td></td>
</tr>
<tr>
<td>Yes, during the last year (4)</td>
<td></td>
</tr>
<tr>
<td>10. Has a relative or friend, or a doctor or other health worker been</td>
<td>Score</td>
</tr>
<tr>
<td>concerned about your drinking, or suggested you cut down?</td>
<td></td>
</tr>
<tr>
<td>Never (0)</td>
<td></td>
</tr>
<tr>
<td>Yes, but not in the last year (2)</td>
<td></td>
</tr>
<tr>
<td>Yes, during the last year (4)</td>
<td></td>
</tr>
</tbody>
</table>
Treatment Selection Form

Georgia law requires all DUI offenders to have a Clinical Evaluation and, if required, complete treatment at a provider of your choice. As your Clinical Evaluator, I am recommending that you complete the following ASAM level of treatment:

☐ Level I: 6–12 Weeks  ☐ Level I: 4–12 Months  ☐ Level II & Above:

The statewide providers of this level of treatment can be located on the DUI Intervention Program website http://www.mop.uga.edu. In this general area, the Treatment Providers are listed below or attached to this name. Circle the Provider you wish to use for treatment sign & date below.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Reg</th>
<th>Service Name</th>
<th>City</th>
<th>County</th>
<th>Contact Info</th>
<th>Type</th>
<th>ASAM</th>
<th>Languages Comment</th>
<th>Max Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebecca Payne</td>
<td>3</td>
<td>Choice Counseling and Evaluation Services</td>
<td>Chattanooga</td>
<td>CHEROKEE Canton</td>
<td>Payne 150 North Street Suite B Canton GA 30114 770-594-5317</td>
<td>TP</td>
<td>I</td>
<td>Outpatient Services</td>
<td>0</td>
</tr>
<tr>
<td>Carol Mann</td>
<td>3</td>
<td>Choice Counseling and Evaluation Services</td>
<td>Chattanooga</td>
<td>CHEROKEE Canton</td>
<td>Mann 150 North Street Suite B Canton GA 30114 678-520-8010 678-763-5860</td>
<td>TP</td>
<td>I</td>
<td>Outpatient Services</td>
<td>0</td>
</tr>
<tr>
<td>Joseph Thompson</td>
<td>3</td>
<td>Ponce de Leon Counseling Service</td>
<td>Chattanooga</td>
<td>CHEROKEE Canton</td>
<td>Thompson 270 E. Main St. Canton GA 30114 404-640-2122 404-589-4445</td>
<td>TP</td>
<td>I</td>
<td>Outpatient Services</td>
<td>0</td>
</tr>
<tr>
<td>Christy Cushing</td>
<td>3</td>
<td>Price Counseling Center</td>
<td>Chattanooga</td>
<td>CHEROKEE Canton</td>
<td>Cushing 2920 Marietta Hwy Suite 132 Canton GA 30114 770-479-5501 770-479-5502</td>
<td>TP</td>
<td>I</td>
<td>Outpatient Spanish Services</td>
<td>0</td>
</tr>
<tr>
<td>Caroline Roberts</td>
<td>3</td>
<td>Price Counseling Center</td>
<td>Chattanooga</td>
<td>CHEROKEE Canton</td>
<td>Roberts 2920 Marietta Hwy, Ste 132 Canton GA 30114 (770) 479-5501</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grace Price</td>
<td>3</td>
<td>The Price Counseling Center</td>
<td>Chattanooga</td>
<td>CHEROKEE Canton</td>
<td>Price 2920 Marietta Hwy #132 Canton GA 30114 (770) 479-5501</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Client Signature ___________________________ Date ___________________________
RELEASE OF INFORMATION

NAME OF PATIENT: ________________________________

The Price Counseling Center is hereby authorized to release to and/or receive from:

____________________________________________________

____________________________________________________

____________________________________________________

the following documents and/or information (please initial all that apply):

- Notification of Initial Contact
- General Treatment Information
- Periodic Progress and Evaluation Reports
- Attendance Reports
- Other: ______________________________________________________

I hereby release The Price Counseling Center from any and all liabilities, responsibilities, damages and claims which might arise from the release of the information authorized above. I acknowledge that this consent is valid for sixty (60) days or until ___________________________.

I further understand that I can withdraw this consent for release of information at any time prior to the expiration date by giving written notice to The Price Counseling Center.

Patient’s Signature: ________________________________ Date: ______________

Patient’s Representative: ____________________________ Date: ______________

Witnessed: ________________________________________ Date: ______________

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL
This information has been disclosed to you from records whose confidentiality is protected by federal law (42 CFR Part 2/37 CFR 1401) and in compliance with Section 408 of Public Law 92-255 (21 USC 1175). You are prohibited from making any further disclosure without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.
ALCOHOL AND DRUG PROGRAM TREATMENT CONTRACT

I, ________________________, agree to participate in the alcohol and drug program offered at The Price Counseling Center.

Rules:

I agree to pay $25.00 per group for ________________ groups or $100.00 for individual sessions for ________________ of sessions beginning ____________________.

I understand that I must attend ____ hours of counseling per week for ________________ weeks.

I will not attend meetings under the influence of alcohol or drugs.

I am aware that the doors will be closed to the groups at 10 minutes after the hour.

Missing groups or attending late may jeopardize my graduation from the program.

All missed sessions must be made up within the week.

I understand that I may have to add individual sessions to remain in compliance with my treatment program.

I will abide by rules of confidentiality.

I will respect the confidentiality of others in my group.

Upon completion of treatment and payment in full for treatment services rendered, I will be given notification of my completion. This notification may aid in regaining my Georgia Driver’s License.

________________________________________  _______________________
Client                                      Date

________________________________________  _______________________
Therapist                                   Date
ALCOHOL/DRUG QUESTIONNAIRE
ADAPTED MAST

1. Please list any drugs you have used besides alcohol:

   Yes  No   Marijuana
   Yes  No   Cocaine (crack, powdered, freebase)
   Yes  No   Methamphetamine or Amphetamines
           (Crank, Ice, “Nazi dope”)
   Yes  No   Tranquilizers (Xanax, Ativan, Valium, etc)
   Yes  No   Ecstasy (MDMA)
   Yes  No   Pain pills (Oxycontin, Demerol, Dilaudid, etc)
   Yes  No   LSD, PCP, “K”, peyote
   Yes  No   Steroids
   Yes  No   Other ______________________

2. The day after using any substance, have you experienced agitation, tremors, headache, nausea, hallucinations, skin crawling, or seizures? (Please circle those that apply.)

3. What is your most preferred drug? Include alcohol ______________________
   How do you use your drug of choice? ______________________

   Yes  No   4. Have you ever awakened the morning after alcohol or drug use the night before and found that you could not remember a part of the evening before?
   Yes  No   5. Does your spouse (or do your parents) ever worry or complain about your alcohol or drug use?
   Yes  No   6. Can you stop drinking or taking drugs without a struggle after one or two drinks, hits, pills, etc?
   Yes  No   7. Do you ever feel bad about your use of alcohol or drugs?
   Yes  No   8. Do you ever try to limit your use to certain times of the day or to certain places?
   Yes  No   9. Are you always able to stop using or drinking when you want to?
   Yes  No  10. Have you ever attended a meeting of Alcoholics Anonymous (AA), NA, CA?
   Yes  No  11. Have you gotten into fights when using or drinking?
   Yes  No  12. Has using/drinking ever created problems with you and your wife, girlfriend, boyfriend, etc.?
   Yes  No  13. Has your spouse (or other family member) ever gone to anyone about your use of alcohol or drugs?
   Yes  No  14. Have you ever lost friends or girlfriends/boyfriends because of alcohol or drug use?
   Yes  No  15. Have you ever gotten into trouble at work because of drinking?
   Yes  No  16. Have you ever lost a job because of drug or alcohol use?
   Yes  No  17. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking or drugging, or recovering?
   Yes  No  18. Do you ever drink before noon, or use drugs in the a.m.?
   Yes  No  19. Have you ever been told that you have liver trouble? Cirrhosis, lung problems or stomach problems? Skin problems, tooth decay due to drug use?
   Yes  No  20. Have you ever gone to anyone for help about your use of alcohol and/or drugs?
   Yes  No  21. Have you ever been in a hospital because of substance abuse?
   Yes  No  22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where substance abuse was part of the problem?
   Yes  No  23. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drugs or
alcohol played a part?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Have you ever been arrested, even for a few hours, because of behavior induced by substance abuse, such as public intoxication, fighting, BUI, etc?</td>
<td></td>
</tr>
<tr>
<td>25. Have you ever been arrested for driving after using alcohol?</td>
<td></td>
</tr>
<tr>
<td>26. Have you ever been arrested for DUI after using drugs or for possessing drugs?</td>
<td></td>
</tr>
<tr>
<td>27. Have you ever failed a drug screen at work?</td>
<td></td>
</tr>
<tr>
<td>28. Have you ever used alcohol or drugs while on probation?</td>
<td></td>
</tr>
<tr>
<td>29. Have you ever passed up a job because you didn’t want to be drug screened?</td>
<td></td>
</tr>
<tr>
<td>30. Have you ever sold drugs?</td>
<td></td>
</tr>
<tr>
<td>31. Have you ever had an open case with a local DFCS agency - which involved drug use?</td>
<td></td>
</tr>
<tr>
<td>32. Have your children ever been removed from your home because of drugs?</td>
<td></td>
</tr>
<tr>
<td>33. Have you ever had a meth lab in your home, car, storage facility, out building?</td>
<td></td>
</tr>
<tr>
<td>34. Have you ever failed a drug screen as part of a DFCS investigation?</td>
<td></td>
</tr>
<tr>
<td>35. Have you ever refused a drug screen which was part of a DFCS investigation?</td>
<td></td>
</tr>
<tr>
<td>36. Have you ever stayed up for 24 hours or more using drugs?</td>
<td></td>
</tr>
</tbody>
</table>

How long have you stayed up using drugs at your peak? ____________

List your arrests - lifetime (include dates): ____________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
Multiple DUI Offender Clinical Evaluation
(Print Legibly or Type - Attach additional sheets as needed)

Date Evaluation Started ___________________________ Date Evaluation Completed ___________________________

Clients Full Name (Print): ___________________________
           FIRST  MIDDLE  LAST

Current Mailing Address:
        Street Address (NO PO BOX NUMBERS)  City  State  Zip-code

Home Phone No: (____) ___________________________
                 Cell Phone No (____) ___________________________

Work Phone No: (____) ___________________________
                 Date of Birth: _____ / _____ / _____

Drivers License #: ___________________________
                 Social Security #: ___________________________

RRP Completion Date: _____ / _____ / _____  Risk Reduction Completion #: ___________________________

Evaluator Name: ___________________________
                 Number: C

Offender Personal Identifying Information Narrative
(Include following information: Precipitating event and related circumstances; Age; Gender, Race / Ethnicity; Marital status; Education history; Referral source and referral's relationship to offender)
Employment History Narrative - provide employment history over 5 years prior to evaluation
(Include Employer name; Length of employment; Status - full or part time; Occupation; Reason for
unemployment if applicable; Reason left previous employer if applicable)

Legal / Criminal History Narrative - provide legal history over past 5 years prior to evaluation
(Include following information: DUI dates and BAC levels; Other traffic charges; Legal history current and
past; pending charges; Probation / Parole status. (Also obtain 7-year Motor Vehicle Report as collateral
verification)
ASAM DIMENSION 1 - Alcohol or Substance Use Intoxication / Withdrawal Potential
The goal for Dimension 1 is to determine if the offender is in need of immediate stabilization or detoxification services.

(Include Substance use history; Pattern - frequency, dose, quantity; Tolerance, blackouts, tremens; Noted withdrawal signs / symptoms; Current use pattern; Age of first use; Date last used; Longest time of sobriety; If sober, sobriety date)

Assessment considerations include:
• What level is risk is associated with offender’s current pattern of use?
• Are there current signs of intoxication or withdrawal?
• What supports does offender have to assist in detoxification or treatment if recommended?

Current ASAM Severity rating for Dimension 1 (circle)  Low  Moderate  High
ASAM DIMENSION 2 - Biomedical Conditions and Complications.
The goal of Dimension 2 is to determine the presence of any medical or chronic conditions, including medications regimen that may require a referral, or that may affect a treatment recommendation.

(Include Medical History, Current / chronic conditions needing attention; Current medication use / dose / frequency / diagnosis or condition if known. Clinical Evaluator may want to conduct a phone consultation / collateral interview with prescribing physician to confirm)

Assessment considerations include
- Are there current physical illnesses, other than withdrawal, that needs to be addressed because they create risk or may complicate treatment?
- What chronic conditions are present that might affect treatment or might be exacerbated by withdrawal (e.g., diabetes, hypertension)?
- Are medications that might affect treatment? What medication management process is in place to determine if offender is taking medications as prescribed?

Current ASAM Severity rating for Dimension 2 (circle) Low Moderate High
ASAM DIMENSION 3 - Emotional, Behavioral, or Cognitive Conditions and Complications
The goal of Dimension 3 is to determine the presence of any mental health, psychiatric or other
cognitive conditions that may require referral or affect a treatment recommendation.

(Mental Status Examination. Include Mental Health / Psychiatric History, Homicidal / Suicidal ideation or intent; Domestic Violence History, Impulse control pattern; Changes in mental status)

Assessment considerations include:
• Are there current psychiatric illness or psychological, behavioral, emotional or cognitive problems that need to be addressed?
• Are there chronic conditions that may complicate treatment?
• Is the offender on any psychotropic medications that might complicate treatment?
• Do emotional, behavioral or cognitive problems appear to be part of addictive disorder?
• If yes to previous question, is a referral for a mental health examination or treatment warranted?

Current ASAM Severity rating for Dimension 3 (circle)    Low    Moderate    High
DIMENSION 4 - Readiness to Change
The goal of Dimension 4 is to determine the offender’s emotional and cognitive awareness of the need to change. The offender's level of commitment to, and readiness for, change indicates his or her degree of cooperation with treatment. In addition, readiness to change indicates the offender's awareness of the relationship of substance use to negative consequences. The degree of readiness to change helps to determine the setting and intensity of treatment rather than the offender's eligibility for treatment itself.

Assessment considerations include
• Does offender feel coerced into treatment or actively objecting to receiving treatment?
• What is the degree of willingness to change?
• If willing to accept treatment, how strongly does offender agree with other's perceptions that s/he has an addiction problem or understands the complications that substance use has created?
• Is the offender compliant solely to avoid negative consequences (externally versus internally motivated)
• Is the offender internally distressed in a self-motivated way about his/her substance-related problems?

Current ASAM Severity rating for Dimension 4 (circle) Low Moderate High

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DIMENSION 5 - Relapse, Continued Use or Continued Problem Potential

The goal of Dimension 5 is to determine the risk of continued substance use, awareness of triggers and coping strategies to maintain and support recovery beyond harm reduction and abstinence. The assignment of a level of care should be made on the basis of both history and an assessment of current problems, and not merely history alone.

Also include history of substance use / abuse or emotional / psychiatric / mental health issues within immediate family.

Assessment considerations include:
- Is offender in immediate danger of continued substance use or mental health distress?
- How aware is offender of understanding or using coping skills to reduce use or risk behavior, and enhance sobriety beyond mere abstinence?
- How severe are continued use problems or further distress if the offender is not successfully engaged in treatment at this time?
- How aware is offender of relapse triggers, ways to cope with craving to use, and skills to control impulses to use or engage in harmful behaviors?
- What is the offender's ability to remain abstinent based upon supportive evidence and collateral interviews?
- What is the offender's current level of craving?
- How successfully can the offender resist using?

Current ASAM Severity rating for Dimension 5(circle) Low Moderate High
DIMENSION 6 - Recovery / Living Environment
The goal of Dimension 6 is to determine the stability of the offender's living environment and offender supports to improve the likelihood of recovery.

Assessment considerations include:
• Are there any dangerous family or significant others, living or working situations threatening treatment engagement and success?
• Does the offender have supportive friendship, financial, or vocational resources to improve the likelihood of successful treatment?
• Are there barriers to access treatment?
• Are there legal, vocational, social service agency, or criminal justice mandates that may enhance motivation for engagement into treatment?
• Are there transportation, childcare, housing, or employment issues that need to be clarified and addressed?

Current ASAM Severity rating for Dimension 6 (circle)  Low  Moderate  High
RISK ASSESSMENT

What is offender consider his/her phase adjusted low risk guidelines (from Risk Reduction program)?

How has attending Risk Reduction Program made a difference in offender's life?

What is offender's plan to maintain abstinence / low risk patterns for the future? What supports are in place?

History of Domestic Violence?  ☐ Yes  ☐ No

*Issues should be explored thoroughly to determine if they are a factor in the offender's substance use history*

Comments:

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SUBSTANCE ABUSE TREATMENT HISTORY

Has offender participated in substance abuse treatment since last DUI? □ Yes □ No

Name of treatment program / facility: ________________________________

Dates of treatment: From _______/_______/_______ To _______/_______/_______

Reason for termination of treatment:
( ) Completed Attach Discharge Summary from facility
( ) Referral to another level of care or another facility or
( ) Early discharge.

Explain nature of circumstances of premature discharge or transfer:
____________________________________________________________________
____________________________________________________________________

Discharge Recommendations. (Has offender followed discharge recommendations - please explain) ________________
____________________________________________________________________
____________________________________________________________________

TEST RESULTS and SUMMARY

(Include copy of NEEDS Assessment if submitting to DBHDD for release from treatment recommendation. NEEDS Assessment can be transferred with Clinical Evaluation to Treatment Provider ONLY when offender has signed authorization to release evaluation packet).

NEEDS Assessment Score: _______ NEEDS Assessment ASAM Level Recommendation: ________________

Other relevant NEEDS Assessment Information: ____________________________________________________________

____________________________________________________________________

Additional Testing Instruments Narrative
(Include name of instrument, date administered, results, and impressions / recommendations)
CLINICAL IMPRESSIONS and RECOMMENDATIONS
Clinical Impressions should be provided in the form of an Interpretive Summary.
Clinical observations and insights include information about the following, but may not be limited to:

1. Behavior and Appearance
2. Affect
3. Intellectual Functioning
4. Interpersonal Relationships
5. Self-concept
6. Character structure
ASAM LEVEL OF CARE RECOMMENDED:

Level 1    E    Level 11.1  E    Level 11.5  E
Level 11.1  E    Level 11.5  E    Level 11.7  E
Level 1V    E

No further treatment recommended

CLINICAL EVALUATOR'S PROFESSIONAL AFFIRMATION

I affirm the included information and attachments are an accurate presentation of the clinical evaluation I have conducted on the identified offender on the stated date. I understand that the records can be requested for review by the Department of Human Resources, Division of MHDDAD, Public Safety - Risk Reduction Unit.

Clinical Evaluator Signature       Credentials       Date

Printed Name of Clinical Evaluator

Address                                      City         State         Zip

Day Telephone Number: (___) ________________  Fax Number: (___) ________________
TREATMENT RECOMMENDATION INSTRUCTIONS:

When making a treatment recommendation, the Clinical Evaluator will send the following to the Treatment Provider:

- Page 1 – demographic information
- Page 11 – Clinical Impressions
- Page 12 – Levels of Care recommendation and signature page
- NEEDS Assessment from Risk Reduction Program

OR

REQUEST TO RELEASE THE OFFENDER FROM THE OBLIGATION OF TREATMENT (REQUIREMENT MET PROCESS) INSTRUCTIONS,

ADDITIONAL DOCUMENTATION MUST BE TO INCLUDED IN THE PACKET SUBMITTED TO THE DIVISION

1. Entire Clinical Evaluation Format

2. 7-year Motor Vehicle Report
   Can be obtained from local Georgia State Patrol or licensing office.
   There is a small fee to obtain the 7-year MVR

3. NEEDS Assessment from Risk Reduction Program

4. Relapse prevention plan or risk reduction plan.
   The offender needs to submit a written plan in his / her words about how things are different now compared to when s/he incurred the DUI's. What s/he learned from Risk Reduction Program that s/he is applying in his/her life today? Triggers; Low risk phase adjusted guidelines; Reducing risk; Plan to maintain sobriety and reduce the probability of another DUI offense.

5. Discharge summary from treatment program / facility (if engaged in treatment prior to evaluation)

GEORGIA MULTIPLE DUI OFFENDER PROGRAM

GUIDELINES FOR VERIFICATION OF INFORMATION

You must obtain documentation of sobriety or low risk choices in the form of notarized affidavits from people in your community who have frequent contact with you and may know something about your drinking and/or use of controlled substances. This would include:

1. Probation/Parole Officer, Local Police
2. Relatives/Including Spouse.
3. Friends
4. Pastors, Ministers
5. Recognized Support Group Members / Sponsor: AA/NA/CA/COA
6. Treatment Provider, Therapist, Physician, Social Worker, Aftercare coordinator

If any of the requested information is received from anyone listed above in a face to face interview or telephone conversation with the clinical evaluator, the documentation of the interview is not required to be notarized.

A treatment provider's discharge summary or a therapist's or physician's testimony must be in writing and on official letterhead and does not have to be notarized.

All letters of testimony above should be signed, dated, and notarized. All letters and interviews recorded by the clinical evaluator should contain at least the following information:

< How often do you see the offender?
< What is your relationship with the offender?
< How long have you known the offender?
< How often do you see or did you see the offender drink or use drugs?
< How much do/did you see the offender drink or consume at the time?
< When was the last time you saw the offender use alcohol or other drugs?
< In what activities does the offender participate involving alcohol?
< What is you knowledge of the offender's involvement in treatment or support groups?
< Include other information you believe is important for us to consider in our review of this offender's eligibility for driver's license reinstatement.

If there is a request for release from the obligation to participate in substance abuse treatment, failure to comply with the verification guidelines may lead to a delay in the review of the request or possible denial of the recommendation.

You may use the attached form for verification.

All letters of verification, other than the attached format, must be on formal stationary and notarized.
GEORGIA MULTIPLE DUI OFFENDER PROGRAM
GUIDELINES FOR VERIFICATION OF INFORMATION

You must obtain documentation of sobriety or low risk choices in the form of notarized affidavits from people in your community who have frequent contact with you and may know something about your drinking and/or use of controlled substances.  
All letters of verification other than this form should be on formal stationary, signed, dated, and notarized.

OFFENDER'S NAME: _____________________________ DATE: ________________________

< How often do you see the offender?

< What is your relationship with the offender?

< How long have you known the offender?

< How often do you see or did you see the offender drink or use drugs?

< How much do/did you see the offender drink or consume at the time?

< When was the last time you saw the offender use alcohol or other drugs?

< In what activities does the offender participate involving alcohol?

< What is you knowledge of the offenders involvement in treatment or support groups?

< Include other information you believe is important for us to consider in our review of this offenders eligibility for drivers license reinstatement.

Verifying Person's Signature _____________________________ Printed Name _____________________________

Verifying persons street address, city, state, zip code and phone number _____________________________

Notary _____________________________ Date _____________________________ Commission Expiration _____________________________
Georgia Department of Behavioral Health and Developmental Disabilities
Substance Abuse Treatment for DUI Offenders

Client Transfer Sheet

TO:                       
__________________________  ___________________________
Treatment Provider Name    Provider Number

_________________________
(Mailing Address)

FROM:                     
__________________________  ___________________________
Treatment Provider Name    Provider Number

_________________________
Contact Person

_________________________
RE:                        
Client Name

_________________________
Driver's License Number

_________________________
Original

__________________________  ___________________________
DHR ID Number              ASAM Level

__________________________  ___________________________
Service Required          Date of Enrollment

_________________________
Client's Mailing Address

_________________________
Number

_________________________
Client Telephone

_________________________
Date of Birth

The above name person is being transferred to your program:

____ As requested by the Client
____ For appropriate Level of Services
____ Other, __________________________

_______________________________________
Signature of Program Official
Price Counseling Center

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Our Commitment to Protect Your Mental Health and Medical Information

You have a right to privacy with respect to your past, present, and future mental health and medical information. Price Counseling Center is required by law to protect your information and to provide you with this Notice of our legal duties and privacy practices with respect to your protected health information. You have the right to receive a paper copy of this Notice.

We are required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. In the event this Notice is revised, you may request a paper copy of the revised notice.

How We May Use and Disclose Your Protected Health Information

We use and disclose protected health information for a variety of reasons. In general, our use and disclosures fall within the following three categories: treatment, payment, and healthcare operations.

Treatment - We will use your protected health information and disclose it to others as necessary to provide treatment to you. For example, members of our clinical staff may access your record in the course of your care, or share information in the process of coordinating your care. Additionally, disclosure to another facility, community health center, or private practitioner may become necessary for your continued treatment, with a written or oral release of information from you.

Payment - We will use or disclose your protected health information as necessary to arrange for payment of services provided to you. For example, information about your diagnosis and the services we provide to you may be included in a bill that we sent to a third-party payer.

Healthcare Operations - We will use or disclose your protected health information in the course of operating Price Counseling Center or for the healthcare operations of another organization that has a relationship with you. Unless you instruct us otherwise, we may use and disclose information to contact you as a reminder that you have an appointment at our office.

Uses and Disclosures Requiring Your Authorization

We are generally prohibited from using or disclosing your protected health information for purposes other than treatment, payment, and health care operations without your written authorization, unless the use or disclosure is within one of the categories described below. In addition, we generally may not use or disclose psychotherapy notes written by your mental health provider without your written authorization, even for treatment, payment and healthcare operations. You have the right to revoke your authorization in writing at any time, except to the extent that we have already undertaken an action in reliance upon your authorization.

Uses and Disclosures Not Requiring an Authorization

By law, we may use or disclose certain protected health information without an authorization in the following circumstances:

When required by law - We may disclose protected health information when a law requires that we report information about suspected abuse, neglect, or domestic violence, or relating to certain criminal activity, or in response to a court order. We must also disclose protected health information to authorities that monitor our compliance with these privacy requirements.

Judicial and Administrative Proceedings - We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information in certain cases in response to a subpoena, discovery request, or other lawful process, subject to your notice and opportunity to object.
Law Enforcement - We may release medical information if asked to do so by a law enforcement official:
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a subject, fugitive, material witness, or missing person;
- About the victim of a crime, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at Price Counseling Center; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Relating to deceased individuals - We may disclose certain protected health information related to death pursuant to a valid subpoena of a coroner or medical examiner.

To avert a serious threat to health or safety - We may disclose protected health information, in order to avoid a serious threat to your health or safety and the health and safety of the public or another person.

For specific government functions - We may disclose protected health information as required by military authorities, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security and intelligence reasons, such as protection of the President.

Uses and Disclosures to Which You May Object

In the following situations, we may disclose a limited amount of your protected health information if we inform you in advance and you do not object, as long as the disclosure if not otherwise prohibited by law:

To families, friends, or others involved in your care - We may share with these people certain information directly related to their involvement in your care, or payment for your care with your permission. We may share certain protected health information with these people to notify them about your location, general condition, or death.

Your Rights Regarding Your Protected Health Information

You have the following rights with respect to your protected health information:

To obtain access to your protected health information - You generally have the right to see and obtain copies of your protected health information upon written request. We may deny you access to review or copy your protected health information. If your request is denied, we must provide you with a reason for the denial and explain any right to have the denial reviewed. If we grant your written request for copies of your protected health information, we will advise you in advance of any fees we may impose for the costs of copying and mailing.

To request restrictions on uses and disclosures - You have the right to ask that we limit how we use or disclose your protected health information. We will consider your request, but are not legally bound to agree to the restriction. If we do agree to any restriction, we will put the agreement in writing and abide by it except in the case of emergency situations. We cannot agree to limit uses and disclosures that are required by law.

To receive confidential communications - You have the right to request that we communicate with you by using an alternative address or by alternative means. We must agree to your request as long as it is reasonable for us to comply.

To request an amendment - If you believe that your protected health information is incorrect or incomplete, you have the right to request in writing that we amend the information. Your request must include the reason you are seeking a change. We may deny your request if (1) we did not create the information or the information is not part of our records; (2) the information is not permitted to be disclosed; or (3) the information is correct and complete. Any denial must be in writing and must state the reasons for the denial and explain your right to submit a statement of disagreement and to have your statement (and any rebuttal), along with your request and the denial, appended to your record.
CLINICAL REFERRAL TRANSFER FORM

To: ___________________________________________ T: __________________________
(Selected Treatment Provider) (Provider ID #)

Attached are the Case Presentation format and the release of information for clinical evaluation on the client listed below:

Client’s Full Name: ___________________________________________ (Date of Birth)
(Last, First, Middle)

Address: __________________________________________________________
(Include: City, State, Zip)

Driver’s License #: ________________________________________________

DHR ID#: ________________ RRP Course Completion Date: ______________
(RRP Certificate of Completion #)

Evaluator’s Name: _________________________________________________

Address: __________________________________________________________
(Include: City, State, Zip)

Telephone #: (__________) Provider ID#: C: ______________

Date Evaluation Completed: ___________________________________________________________________

ASAM Level of Treatment Referred to:

Level I: ☐ Level II.1: ☐ Level II.5: ☐
Level III.1: ☐ Level III.3: ☐ Level III.5: ☐
Level III.7: ☐ Level IV: ☐ OMT: ☐

I hereby swear (or affirm) that this clinical evaluation was conducted by the undersigned in accordance with the rules of the Department of Human Resources, Chapter 290-4-13, and Georgia law, O.C.G.A. Section 37-7-2.

_________________________________________________________________________
Clinical Evaluator Signature

_________________________________________________________________________
Date

NOTE: Attach this original form to front of Case Presentation and include the release form and mail or fax to Treatment Provider. Place a photocopy of this form in the client’s file. (or the original if faxed)