ICS/DWI/SA Screening & Assessment

Date: ______________________ **SS#:** ______________________

Name: (First) ______________ **(MI)** ______ **(Last)** ______________

Address: ______________________ **Home Phone:** ______________

City/Zip ______________________ **Work Phone:** ______________

Employer: ______________________ **Race:** ______________

Male: _____ **Female:** _____ **Date of Birth:** __________ **Highest Grade Attended:** ______________

Married: ______ **Partnered:** ______ **Single:** ______ **Separated:** ______ **Divorced:** ______ **Widowed:** ______

Emergency Contact: (Name) ______________________ **(Phone)** ______________

DWI CASES ONLY

County of Arrest: ______________

Docket#: ______________

Driver Lic#: ______________

Arrest Date: ______________

Conviction Date: ______________

Breathalyzer Results: ______________

BAC: ________ #Priors: ________ Confirmed: ______

Recom: ______________ DX: ________

Assessor: ______________

Reviewed By: ______________ Date: ______

(Please complete)
Who referred you or how did you choose our agency:

Attorney ______ **Probation** ______ **Phone Book** ______

Employer ______ **Orange St. AWARE Letter** ______

Phoenix Elephant Letter ______ **Court List** ______

EAP ______ **School** ______ **Friend** ______ **Here before** ______

Other: ______________

Attorney: ______________

Probation Officer: ______________

______________ ______________ ______________

Client Signature **Date** **Date Release Expires**

IMPACT CAROLINA SERVICES, INC
Service Agreement

Reinstatement of Driver's License:
To have your license reinstated, you must obtain a certificate of completion by:

A) Completing a substance abuse assessment at an authorized NC DWI Services provider; and
B) Completing the recommended level of treatment or education at an authorized NC DWI Services provider.

Provider Choice:
____ I understand that I have the right to choose to complete my recommended level of substance abuse treatment or education at **any** authorized NC DWI Services provider.
The following resources are available to assist you in finding an authorized NC DWI Services provider in NC:
NC DWI Services Provider List by County: www.ncdwiservices.org
NC DWI Services Main Phone Number: 919-733-0566

Service Level Recommendations:
____ I understand that the following is required to be completed to clear my license.
Level: ________________ Minimum # of hours: ______ Duration (Minimum # of days): ______
Additional requirements (i.e., UDS, BAC): ____

Assessment Policy:
____I understand that if I have **not** begun the recommended substance abuse education or treatment to resolve my DWI **within 6 months from the assessment date** a new assessment and assessment fee will be required.

Complete Driving History:
____I understand that a complete driving history from NC DMV is required for the assessment; I may bring one in or obtain it here **at the cost of $10 or** I can obtained it myself online at: www.ncdot.gov/dmv/online/records

Program Requirements and Fees:
____ I understand that if I complete the recommended level of care at Impact Carolina Services, Inc. these will be the program fees:

20 hours	$325	If paid in full	$400	If paid in installment
30 hours	$425	If paid in full	$500	If paid in installment
40 hours	$525	If paid in full	$600	If paid in installment
60 hours	$725	If paid in full	$800	If paid in installment
Out of state process: $175			Random drug screen: $25.	

Program requirements are attached in a separate sheet

- We do random drug testing and it costs $25.00. * Three unexcused absences will lead to discharged
- Coming drunk/high to group session will lead to dismissal * Fighting or assault in group will lead to dismissal
- If UDS conducted by this facility as a part of the DWI Assessment it is at **No Cost** to the client.

Each treatment client is scheduled to attend services weekly (10A NCAC 27G .3813).

Certificate of Completion (E508) Processing:
___I understand that the provider has two weeks to submit the E508 after completion of services and payment. If you are pre-trial at time of assessment, you MUST inform your Treatment Provider of your conviction date in order to submit the E508 to the state. An additional period of 5 days or more is required to complete the process with DMV. Contact your Treatment Provider with questions regarding the status of your E508.

I certify that I have read, understand, and have received a copy of this Service Agreement.

Signed in acknowledgement at time of assessment or at time of enrollment into education/treatment:

Client's Signature: ____ Date: ____________

Counselor's Signature: ____ Date: ____________

IMPACT CAROLINA SERVICES, INC

1409 East Blvd, Suite 100, Charlotte, NC 28203 Ph. 704-338-1155 Fax 704-342-1917

Emergency Crisis Plan, Consent, & Release/Exchange of Confidential Information

Client Name____ **DOB**____________

Emergency Crisis Plan

In the event of an emergency, we will attempt to render 1st Aid, CPR, and other assistance as appears to be necessary and within the scope of competency. Should any staff member determine that medical or emergency needs exceed the competencies or resources available, we will contact 911 emergency services to assist.

Emergency Contact Information

Additionally, we ask that you list any additional emergency contact information with whom we can release/exchange confidential medical and clinical information, as necessary regarding an apparent emergency.

Emergency Contact: Phone:

Personal Medical Physician: Phone:

Psychiatric or Mental Health Clinician: Phone:

With my signature below, I hereby consent to the release/exchange of confidential information between Impact Carolina Services and the contacts above. I understand the doctrine of Informed consent, and know my records are protected under Federal Confidentiality Laws, which prohibit disclosure without my written consent. This release is made voluntarily, and is valid until such request if fulfilled, and remains valid until all assessment and treatment services are completed.

I also acknowledge that I may revoke this consent at any time, except to the extent that action based on this consent has been taken.

Signed: ____ Date: ____________________

Staff Witness: _______________________________________Date:____________________

CONFIDENTIAL & PRIVILEDGED For Professional Purposes Only. Not For Publication. -Not To Be Used Against The Client's Interest and Not To Be Released To Another Agency Or Person. Title 42. C.F.A.

CONSENT TO INDIVIDUAL RECIPIENT

42 CFR Part 2 and HIPAA

I, ____, authorize

[client's name]

____ to disclose

[name or general designation of individual or entity making the disclosure]

____

[describe how much/what kind of information may be disclosed, including and explicit description of what substance use disorder information may be disclosed; as limited as possible]

to ____

[name of individual(s) who will receive the information]

For the purpose of ____.

[describe the purpose of the disclosure; as specific as possible]

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Client 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 provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

____

[describe date/event/ condition upon which consent will expire; must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form**.**

Dated: _____ _____ ____

Signature of Client

Dated: ___________ ____

Signature of person signing form if not client

____

Describe authority to sign on behalf of client

Dated: ___________ ____

Witness/Staff Signature

Notice prohibiting re-disclosure of Substance Use Disorder Information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a client as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any client with a substance use disorder, except as provided at §2.12(c)(5) and §2.65.

IMPACT CAROLINA SERVICES, INC

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Important Information Regarding Current DWI Assessment/Recommendations with Impact Carolina Services

Client Name____ **DOB**____________

1) Records are kept in confidence, according to Federal Confidentiality Regulations.
2) Any prior/future outstanding DWI charge requires an additional assessment and completion of recommendations.
3) Results should be understood after review with the assessment counselor.
4) All recommendations are conditional upon final review of all driving records and confirmation of breath analysis reports.
5) If additional clinical information becomes available, subsequent to the assessment the finding and recommendations are subject to change.
6) If this is a Pre-trail assessment, a letter will be provided you, which indicates findings and recommendations (pending or complete). This may be used in court as proof of assessment.
7) Upon receipt of all required information, you may enroll in the final recommended level of care immediately. You may also choose to delay entry prior to court action/advice of attorney. Delayed enrollment requires the service provider to conduct an additional intake/review, to determine the appropriateness of a previously made recommendation. You may incur additional expense at this time.
8) After all information is confirmed, if you are referred to ADETS, you will need to contact a provider and that provider will request appropriate assessment documentations to include Form-E508.
9) If this is a post trial assessment, or upon final disposition by the court, you are required by North Carolina law [G.S. 20-179(m)]. To complete the recommended treatment/education before reinstatement of the driving privilege. Verification of completion must be sent to the DMV in order to have privileges restored.

A complete with a list of alternative providers will be provided to you upon completion of assessment.

Client Signed: ____ Date: ____________________

Staff Witness: ____Date:____________________

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Acknowledgement of Notice of Privacy Practices and Statement of Client Rights

Client Name____ **DOB**____________________

I understand my basic rights as a client. These rights include:

1. The right to impartial access to treatment services regardless of race, religion, ethnic background, physical handicap or source of financial support.
2. The right to have personal dignity recognized and respected in all aspects of interaction and contact with facility staff.
3. The right to individualized treatment, including participation in the development of a Treatment plan and implementation of the plan in cooperation with professional staff.
4. The right to confidentially of communication with treatment staff and of material Included in the treatment record; federal confidentially rules (42 CFR part 2) prohibits the release of any information about a client's participation in this program to anyone outside of this agency without a client' written authorization for the disclosures of my protected health information.
5. The right to privacy of health information, under HIPAA, (Health Insurance Portability and Accountability Act). Rules accept where federal or state rules are more restrictive **HIPAA Notice of Privacy Practice** is given to all clients extensively explaining the rules and exceptions to confidentiality in special cases of imminent emergency or court order.
6. The right to express opinions and discuss the plan and course of treatment with persons responsible, and to receive a stated grievance in accordance with established policy.
7. The right to be informed in any rules or exceptions, which apply to the client's conduct and participation in treatment.
8. The right to a satisfactory explanation of treatment services and this statement of rights before giving consent to treatment.
9. The right to notify the staff of discontinuance of treatment at any time without being financially responsible for any planned treatment services that was not provided.
10. The right to be informed of alternative treatment resources other than those provided by Impact Carolina Services.

Grievance Process

I understand that if I have a complaint/grievance, I should:
Submit concerns/grievances in writing to Impact Carolina Services.
If unresolved, I understand that I have a right to contact the agencies below at any time to discuss my complaint/grievance:

DWI Services, Justice Systems Innovations
NC Mental Health/Developmental Disabilities/Substance Abuse Services

Shenita Billups shenita.billups@dhhs.nc.gov

Donna Brown donna.m.brown@dhhs.nc.gov. 3008 Mail Service Center Raleigh, NC 27699-3008
Phone: 919-733-0566 Fax: 919-508-0963

North Carolina Substance Abuse Professional Practice Board

http://www.ncsappb.org/
http://www.ncsappb.org/wp-content/uploads/2012/11/complaints.pdf
P.O. Box 10126 Raleigh, NC 27605

Katie Gilmore, Associate Executive Director
katie@recanc.com

Disability Rights NC

http://www.disabilityrightsnc.org/
3724 National Drive, Suite 100
Raleigh, NC 27612
(877) 235-4210 or (919) 856-2195
Email: info@disabilityrightsnc.org

My signature indicates I have received and understand my rights, received a copy of the HIPAA Notice of Privacy Practice and had an opportunity to ask any questions I may have had.

Client's Signature: ______________________________________Date:______________

Staff's Signature/Title: _________________________________ Date: _____________

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Consent for Impact Carolina Services, INC

Client Name____ **DOB**_____________

By my signature, I acknowledge I have reviewed and understand that:

- My consent for assessment/treatment with Impact Carolina Services is voluntary, and may be discontinued at my discretion, with proper notification.
- All information I disclose to Impact Carolina Services is binding as accurate and truthful. Should conflicting information arise subsequent to the assessment. I understand findings and recommendations may change.
- Documentation of assessment/treatment activity may not be forwarded to the court, attorney or State of North Carolina until full payment is made for services received.
- Releases signed pertinent to the reinstatement of the driving privilege are considered valid until closure. All other releases are valid for one year. The client may revoke any release, with the exception of a specific Criminal Justice System release, at any time, except to the extent information has already been disclosed.
- Impact Carolina Services exchange properly released information verbally and in writing, utilizing telephone, postal and facsimile methods.
- Information may be kept in a computerized record system for statistical/programming purposes, and Impact Carolina Services provides information to a data entry agent, without an additional release.
- Impact Carolina Services prohibit the carrying of any weapon, concealed or visible, on the premises at any time. We also prohibit the possession of alcohol/drugs and drug paraphernalia on the premises.
- In emergencies, Impact Carolina Services will call "911" and assist the responders in crisis resolution.
- Other public/private agencies provide similar services, and it is my right to choose another provider Impact Carolina Services makes available a list of such providers.

Client Signature: ____ Date: ______________________

Staff Witness: ____ Date: ______________________

IMPACT CAROLINA SERVICES, INC
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Driver Privacy Protection Act Authorization to Disclosure personal Information (DL-SPPA-2)

I understand that personal information contained in my Motor Vehicle records is protected by the Federal Driver Privacy Protection Act and NC General Status 20-43. I hereby authorize that the personal information in my file be released to the following:

Information to be received by: Impact Carolina Services, Inc
1409 East Blvd, Suite 100
Charlotte, North Carolina 28203

Attn: Dr. Joseph Adedokun, MAC, LCAS,

Client Signature: ____

Print Your Name as it appears on your license: ____

Client Driver License/ID number: _________________________

Client Date of Birth: ___________________

Client Social Security number (required): ________________________

Phone number: ____

Date: _______________

IMPACT CAROLINA SERVICES, INC.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
CRIMINAL JUSTICE SYSTEM REFERRAL

I, ____ SSN: _______________________authorize:
(Printed name of defendant)

Name or general designation of program making disclosure: *Impact Carolina Services, Inc.*_____________

Initial all that apply:

☐ NC Department of Community Corrections (Officer supervising my case): ____________________________________

☐ NC Division of Motor Vehicles

☐ NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

☐ ____ ☐ ____
(Name of the appropriate court) (Name of the prosecuting District Attorney)

☐ ____ ☐ ____
(Name of the Criminal Defense Attorney) (- Other -)

to communicate with and disclose to one another the following information (nature and amount of the information as limited as possible):

☐ My diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

☐ ____

The purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client 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. 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:

[*Specify the date, event or condition upon which this consent expires. This could be one of the following*:]

☐ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

☐ ____
(Specify other time when consent can be revoked and/or expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form: ____ Date:_______________
(Signature of Client)

Signature of person signing form if not the client: ___________________________________ Date:________________
(Signature)

Describe authority to sign on behalf of client: ____

Client Name: ___________________________________ DOB: ___________ Date: _____________

Substance Use History: Have you ever used any of the following drugs: Please circle the number that best describes your involvement with each drug listed below.

0 – No Problem 1 – Was a problem, but not in the past year 2 – Current problem

Alcohol –0 1 2Cocaine - 0 1 2 Marijuana – 0 1 2 Sedatives - 0 1 2 PCP - 0 1 2

Stimulants (methamphetamines, crank) - 0 1 2 Tobacco - 0 1 2 Club Drugs (Ecstasy, Roofies, Euphoria) – 0 1 2

Inhalants – 0 1 2 Steroids – 0 1 2 Narcotics (Heroine, Oxycotin) – 0 1 2 Other____________0 1 2

Why do/did you use the drugs you circled above? (Circle all answers that apply) Entertain Clients of customers

Relax or unwind Forget my problems Be more Social Have fun Be more creative

For the "buzz" Improve my mood Feel less anxious Help me sleep Relieve physical discomfort

Enjoy taste Out of "habit" Go along with crowd Deal with boredom Be more outgoing

---

Have you experienced any of the following problems as a result of your substance use?
Please circle the number that best describes possible problems you have had:

0 – No Problem 1 – Was a problem, but not in the past year 2 – Current problem

Hangovers	0 1 2	Arrest of tickets	0 1 2
Getting nauseated	0 1 2	Drinking with medical complications	0 1 2
Memory blackouts	0 1 2	Martial problems	0 1 2
Arguments	0 1 2	Worry/Anxiety	0 1 2
Acting "inappropriately" and Regretting my behavior	0 1 2	Low self-esteem	0 1 2
Driving under the influence	0 1 2	Depression	0 1 2
Being late for work	0 1 2	Guilt/Shame	0 1 2
Missing work or school	0 1 2	Separation or Divorce	0 1 2
Less productive at work or school	0 1 2	Lack of motivation	0 1 2
Difficulty controlling how much I use	0 1 2	Suicidal thoughts or impulses	0 1 2
Neglect commitments or responsibilities	0 1 2	Homicidal thoughts or impulses	0 1 2
Accidents resulting in injuries to self/others	0 1 2	Spending to much money	0 1 2
Damage to property including auto accidents	0 1 2	Physical symptoms	0 1 2
Substance abuse education program or Outpatient counseling or treatment	0 1 2	Passing Out	0 1 2
		Relationship Problems	0 1 2
Inpatient substance abuse treatment/detox	0 1 2		

Client Name: ____ DOB: ____________ Date: ______________

Substance Use History (continued)

Skip sections marked counselor note or review:

Family substance use: Circle the number that best describes issues your biological family had with alcohol or other drugs

0 – No Problem **1 – Was a problem, but not in your past** **2 – Current problem**

Father – 0 1 2 Mother – 0 1 2 Brother – 0 1 2 Sister – 0 1 2

Paternal Grandfather – 0 1 2 P/Grandmother – 0 1 2 Maternal Grandfather – 0 1 2 M/Grandmother – 0 1 2

Uncle/Aunt – 0 1 2 Step parent – 0 1 2 Step Sibling – 0 1 2

Were you raised in a family where an adult was a heavy alcohol or other drug user? NO YES

If so who?___________________________________and how do you feel it effected you?________________________
Relationship

Counselor Note:____

On average, over the last year how many days did you use alcohol or other drugs?

Alcohol:______days per (Circle one of the following) WEEK MONTH YEAR

Other drugs: ________________________ days per week (Circle one of the following) WEEK MONTH YEAR
(name of drug)

Other drugs: ________________________ days per week (Circle one of the following) WEEK MONTH YEAR
(name of drug)

Other drugs: ________________________ days per week (Circle one of the following) WEEK MONTH YEAR
(name of drug)

On the days you use alcohol, how many drinks do you usually have 0 1 2 3 4 5 6 7 8 9 10+
Circle the average number of drinks or range

Have you had prior alcohol related arrest (s)? NO YES If yes, how many?______________________________

Counselor note: When were arrests____?

Have you had prior drug related arrest(s)? NO YES If yes, how many? ______________________________

Presenting problem: What happened that made you decide to come for this assessment? Briefly describe the event(s), including your legal status, such as: no charges, court pending, convicted probation.

____

____

If you were drinking, how much did you have to drink? _________________ over what period of time (how long/frequency)?
# of Drinks

_______________from: ________to __________
time of day

(One drink is equal to 12-oz. Regular beer; 5-oz glass of 12% wine; or 1.5 oz of 80 proof liquor/mixed drink).

What did you eat on the day you described above? ____

If you received a DWI, what was your BAC? (breathalyzer reading)________What time were you arrested?__________

On a scale of 0 to 10, estimate how drunk or impaired you felt just before the event occurred (before you were stopped by the police). This question is not asking how "tired" or whether you "knew" you were impaired. If is asking how drunk or impaired you felt. Circle the most appropriate number below.

Stone cold sober 0.....1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Passed out drunk

Counselor note: Review pages 1-3 and SASSI____

____