

MOUNT ROGERS ALCOHOL SAFETY ACTION PROGRAM
CLIENT-COMPLETED CASE SUMMARY SHEET

COMPLETE ALL QUESTIONS AS FULLY AS POSSIBLE AND PLEASE PRINT

FULL NAME: _____

ADDRESS: _____

COUNTY OF RESIDENCE: _____

NEAREST METROPOLITAN AREA: _____

NAME & ADDRESS OF AGENCY YOU WISH TO BE TRANSFERRED TO:
(ALCOHOL/DRUG EDUCATION PROGRAM-20 HOURS MINIMUM)

PHONE: _____

HOME PHONE #: _____ WORK PHONE #: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

SEX: MALE _____ FEMALE _____ MARITAL STATUS: _____ # MARRIAGES: _____

SPOUSE'S NAME: _____ NUMBER CHILDREN: _____

YEARS EDUCATION: _____ OCCUPATION: _____ YEARLY INCOME _____

JOBS IN PAST 5 YEARS: _____ PRESENT EMPLOYMENT: _____

STATE DRIVERS LICENSE ISSUED: _____ LICENSE #: _____

THIS DUI ARREST DATE: _____ TIME OF ARREST: _____ ACCIDENT: YES _____ NO _____

BLOOD ALCOHOL CONTENT AT TIME OF ARREST: _____ BLOOD TEST _____ BREATH TEST _____

OFFICER WHO MADE ARREST: TOWN _____ COUNTY _____ STATE POLICE _____ OTHER _____

PREVIOUS ASAP PLACEMENT: YES _____ NO _____ YEAR: _____ LOCATION: _____

PREVIOUS ALCOHOL TREATMENT: YES _____ NO _____ YEAR _____ LOCATION: _____

NUMBER PRIOR DUI ARRESTS: _____ YEARS _____ LOCATION: _____

PRIOR RECKLESS DRIVING ARRESTS: _____ # PRIOR IMPROPER DRIVING ARRESTS: _____

NUMBER DRUNK IN PUBLIC ARRESTS: _____ DATES: _____

I UNDERSTAND THAT INFORMATION COLLECTED ON THIS FORM WILL BE DISSEMINATED TO AGENTS OR AGENCIES FOR PURPOSES RELATING TO MY PROBATION STATUS. THIS INFORMATION WILL BE DISSEMINATED ONLY IN ACCORDANCE WITH THOSE INSTRUCTIONS CONTAINED WITHIN YOUR SIGNED RELEASE AUTHORIZING THE DISSEMINATION OF THIS DATE.

SIGNATURE _____ DATE _____

VASAP CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION - GENERAL

✓ Probationer: _____ ✓ Date of Birth: _____

I hereby grant the Virginia Alcohol Safety Action Program (VASAP) consent to exchange information related to my ASAP requirements with:

- the court of record/referral
- the Commonwealth Attorney's office
- attorney(s) of record
- local, state and federal law enforcement agencies
- other criminal justice entities
- the Virginia Department of Motor Vehicles
- applicable VASAP ignition interlock service providers
- other (specify) _____

I understand that if I am being referred to the Alcohol Safety Action Program **by a court**, information concerning my participation will be reported to the court, and my consent for that purpose will terminate upon successful completion of my ASAP probation. In the event of noncompliance, this Consent for Release of Confidential Information will not expire until the referring court formally terminates the Alcohol Safety Action Program's oversight of the case.

I understand that if I am enrolling in the Alcohol Safety Action Program to complete a **DMV requirement**, this Consent for the Release of Confidential Information shall expire automatically upon termination of my ASAP participation.

I understand that my records are protected under Federal Confidentiality Regulations (42CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I further understand that all treatment information is protected under HIPAA and cannot be released by the ASAP without my consent; however, should I elect to transfer to another ASAP, all records to include treatment records will be sent to the supervising ASAP in order to effectively administer my case. A copy of this Consent for Release of Confidential Information form shall be considered to be valid as the original.

✓ Executed this _____ day of _____, 20_____

✓ Participant's Signature: _____

Parent/Guardian Signature (required if under the age of 18): _____

To revoke consent for release of information, complete this section.

Date Revoked: _____

Participant's Signature: _____

Parent/Guardian Signature (if required): _____

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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.

VASAP CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION - INDIVIDUAL

Probationer: _____ Date of Birth: _____

I hereby grant the Virginia Alcohol Safety Action Program (VASAP) consent to exchange information related to my ASAP requirements with the following individual(s):

(Full Name) (Assigned Password)

(Full Name) (Assigned Password)

(Full Name) (Assigned Password)

I understand that my records are protected under Federal Confidentiality Regulations (42CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I further understand that all **treatment** information is protected under HIPPA and cannot be released by the ASAP without my consent; however, should I elect to transfer to another ASAP, all records to include treatment records will be sent to the supervising ASAP in order to effectively administer my case.

This Consent for the Release of Confidential Information shall expire automatically upon termination of my ASAP participation. A copy of this Consent for Release of Confidential Information form shall be considered to be valid as the original.

Executed this _____ day of _____, 20_____

Participant's Signature: _____

Parent/Guardian Signature (required if under the age of 18): _____

To revoke consent for release of information, complete this section.

Date Revoked: _____

Participant's Signature: _____

Parent/Guardian Signature (if required): _____

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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.

AGREEMENT TO PARTICIPATE FOR OUT OF STATE TRANSFERS

Under the provision of Section 18.2-271 of the Code of Virginia, the Court has placed you on probation for approximately one year or until your ASAP obligation is fulfilled.

It is understood that circumstances related to my convenience require referral to a facility other than generally utilized by the Mount Rogers ASAP for the provision of Driver Alcohol Education and/or Treatment. This referral is being made to accommodate the probationer.

I understand that agents or agencies in the state to which I am referred may have costs that I must assume which are not covered by the ASAP fee.

TERMS OF PROBATION

1. I understand that I am to obey all municipal, County, State and Federal laws and ordinances.
2. I am required to advise my case manager of any change in address, phone number or other change which affects my situation.
3. I understand that any subsequent alcohol or drug related offense is a violation of my ASAP probation and must be reported to my ASAP case manager within 24 hours of the arrest.
4. I understand that I am to be truthful and cooperative with all ASAP personnel and to agencies to which I am referred by the ASAP.
5. I agree to comply with the rules, regulations and recommendation of any education and/or treatment agency to which I am referred for services.
6. I understand that I am to be totally free of alcohol whenever I am at the ASAP office or at any agency to which I am referred to for services.
7. I understand that I am to contact my ASAP Case Manager immediately if I am unable to complete the program at the agency to which I am referred.
8. I understand that any violation of these terms of probation could result in my case being returned to court for non-compliance and the imposition of sanctions previously suspended by the court.
9. I understand that I am required to attend all appointments and classes scheduled by the agency to which I am referred.
10. I understand that the ASAP fee is non-refundable and non-transferable.
11. I will VERIFY that reports on my enrollment and completion are returned to Mt. Rogers ASAP.

By my signature below I acknowledge receipt of these Terms of Probation and agree to the conditions set forth. I understand that failure to comply with these terms of probation may result in my case being returned to court as non-compliant.

Signature of Probationer

Date

Mt. Rogers Alcohol Safety Action Program (ASAP)

Court Diversion Alternatives Program (CDAP)

Driver Improvement Program (DIP)

Pam R. Williams: Director

730 South View Drive, Marlon, VA 24354

PHONE: 276-783-7771 (ASAP & CDAP)

276-783-5737 (DIP)

FAX: 276-783-7855

ALCOHOL SAFETY ACTION PROGRAM

EMAIL AUTHORIZATION DISCLAIMER

You have requested that we communicate with you by e-mail.

Due to the risk that electronic messages can be misdirected, hacked or intercepted by unintended parties, the Alcohol Safety Action Program does not guarantee the confidentiality of messages sent over the internet. Email sent over the internet is especially vulnerable to privacy breaches or unintended disclosures. In addition messages sent to or received from work email accounts also may be monitored or viewed by your employer.

I hereby authorize the ASAP to communicate with me by email. I acknowledge that I have read the Alcohol Safety Action Program Email Authorization.

SIGNATURE: _____

NAME: _____

DATE: _____

DOB: _____

EMAIL: _____