

# LAKE AREA RECOVERY CENTER

## DRIVER'S INTERVENTION PROGRAM

The cost of the class is **\$400.00** (we accept cash, credit cards, money orders and checks). Please inquire about the cost if you are on SSI, Disability or Medicaid (you must provide valid documentation). Payments may be made. Even though payments are made, remember you will NOT be able to attend the class until the fee for the program is paid in full. The \$30.00 non-refundable registration fee you are paying today is part of the \$400.00 fee. Should you need to reschedule or cancel after a class date has been assigned, there is a \$100 cancellation/rescheduling fee.

If the court did not give you a set date to complete the class – the AWARE program will give you up to FOUR months to complete payment and schedule your class.

- Complete all forms
- Sign all the places on each page that require a signature

### KEEP IN MIND CLASSES FILL UP QUICKLY

Do not wait until the last minute to pay and be assigned to a class.

**Private rooms are available at an additional cost (if rooms are available)**

**THE COST OF AWARE CLASSES IS SUBJECT TO CHANGE AT ANY TIME**

**Mail paperwork and/or payments to:**

**AWARE Program  
Lake Area Recovery Center  
2801 C Court  
Ashtabula, OH 44004**

**Any questions, please feel free to contact our office at 440-998-0722**

**HANDICAPPED FACILITIES ARE AVAILABLE. PLEASE INFORM THE FRONT DESK IF THIS SERVICE IS NEEDED**

**KEEP THIS PAGE FOR FUTURE REFERENCE**

# Lake Area Recovery Center

2801 "C" Court  
Ashtabula, Ohio 44004

Phone: (440) 998-0722

Fax: (440) 992-1699

## Aware Registration

Last Name:		First Name:			MI:	
Mailing Address (Apt./Lot # or PO Box):			City:		State:	Zip:
Phone: ( )		SS#	Sex:	Age:	Date of Birth:	
Email:			Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Nat. <input type="checkbox"/> Other _____			
Do you have reading difficulties? <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>IN CASE OF EMERGENCY CONTACT:</b> Name: Address: City State Zip Phone: ( ) Relationship to Client			
Court that referred you: <input type="checkbox"/> Ashtabula Municipal Court <input type="checkbox"/> Western County Court (Geneva) <input type="checkbox"/> Eastern County Court (Jefferson) <input type="checkbox"/> Conneaut Municipal Court <input type="checkbox"/> Other: _____ (specify)						
What is your Court Case #?: _____						
What was your BAC?						
<b>ANY SPECIFIC EMERGENCY INFORMATION :</b>						
Client Signature:				Date:		
<input type="checkbox"/> Self Pay <input type="checkbox"/> Medicaid/SSI/SSDI						
Medicaid Number:						

**CONSENT FOR THE RELEASE OF INFORMATION CRIMINAL JUSTICE SYSTEM REFERRAL**

I, \_\_\_\_\_, hereby consent to reciprocal communication between **the Lake Area Recovery Center** and

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> WESTERN COUNTY COURT / PROBATION DEPARTMENT | <input type="checkbox"/> ADULT PROBATION DEPARTMENT                    | <input type="checkbox"/> ADULT PAROLE AUTHORITY                          |
| <input type="checkbox"/> ASHTABULA JUVENILE COURT                    | <input type="checkbox"/> EASTERN CO. COURT / PROBATION DEPARTMENT      | <input type="checkbox"/> ASHTABULA MUNICIPAL COURT/ PROBATION DEPARTMENT |
| <input type="checkbox"/> COURT OF COMMON PLEAS                       | <input type="checkbox"/> CONNEAUT MUNICIPAL COURT PROBATION DEPARTMENT | <input type="checkbox"/> OTHER: _____<br>_____<br>_____                  |

**+++BESURE TO HAVE CLIENT INITIAL EACH ITEM THAT IS CHECKED**

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, my cooperation with the treatment program, prognosis, UDS results and as noted below.

Information will be released in the following forms, written, verbal and electronic.

I understand that I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply information that has already been released in response to this authorization.

**Verbal Revocation Clause:** All revocation must be in writing unless the revocation is for Substance Abuse Treatment - in which case verbal revocation is acceptable.

**Re-disclosure:** Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by the following written statement:

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 information in this record that identifies a patient 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 42 CFR 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 42 CFR 2.65. For records relating to mental health services, information from other providers that is contained in the individual client record may be released from the individual client record with the written authorization provided in accordance with the provisions of OAC 5122-27-06. For records relating to addiction services, information from other providers that is contained in the individual client record may be released from the individual client record only if the written authorization provided in accordance with OAC 5122-27-06 explicitly authorizes both the disclosure of provider's records and the re-disclosure of the other provider's records.

**Conditions:** Signing this consent is voluntary. I understand that I will not be denied services with LARC if I refuse to sign. LARC will not condition treatment, payment, enrollment or eligibility on client's authorization for the release of information.

Client Signature:	Date: / /
This authorization will expire upon my release of probation / parole.	
Date of Birth:	
Parent /Guardian Signature (If client is a minor)	Date: / /
Staff Witness Signature:	Date: / /

**CONSENT FOR SERVICES**  
**PLEASE COMPLETE THIS SECTION: DRIVER'S INTERVENTION (AWARE)**

I, \_\_\_\_\_, hereby consent to receive services provided by Lake Area Recovery Center. If at any time I am concerned about the services provided, I understand that I may withdraw consent with formal written notice to LARC.

Client Signature

Date

**X**

**WITNESS**

Staff Signature

Date:

LAKE AREA RECOVERY CENTER

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE AND CLIENT RECORDS

The confidentiality of alcohol and drug abuse records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as a drug or alcohol abuser unless:

- 1) The client consents in writing;
- 2) The disclosure is allowed by a court order that meets the requirements of 42 CFR Part 2.
- 3) The disclosure is made to qualified medical personnel in a medical emergency; or
- 4) The disclosure is made to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client, either at the program or against a person who works for the program, or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

See 42 U. S. C. 290 dd-3 and 42 U. S. C. 290 ee-3 for federal laws and 42 CFR part for federal regulations.

I also understand that, in accordance with the Ohio Revised Code Section 2305.51, if I disclose specific information regarding my intent to seriously harm a specific individual or structure, my counselor is obligated to warn that entity of my intent.

**I have been informed of the above information concerning the confidentiality of alcohol and drug abuse client records and I have received a copy of Lake Area Recovery Center’s Notice of Privacy Practices which explains release of information relative to the Health Insurance Portability and Accountability Act (HIPAA).**

Name of Client (Print) \_\_\_\_\_

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Custodial Parent or Guardian if Client Is a Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Employee Providing Above Information

\_\_\_\_\_  
Date

# LAKE AREA RECOVERY CENTER

## DRIVER INTERVENTION (AWARE) PERMISSION FOR AGENCY CONTACT

I, (Print) \_\_\_\_\_ give my consent to the Lake Area Recovery Center to contact me at the address and phone number that I have designated below. The purpose of the contacts would be to allow notification of program changes affecting my involvement with the agency and to obtain necessary follow-up information for one year following completion of the LARC program services.

I understand that I may revoke this consent at any time by notifying LARC in writing, or I may specify a date, time, event or condition upon which my consent will expire without written notice of revocation. I have read this form, or had it read to me, and I understand its contents.

Address: Street:	
City/State	
Zip	
Phone	

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
LARC Staff

\_\_\_\_\_  
Date

*Lake Area Recovery Center*  
**AWARE CONTRACT**

**PROGRAM ATTENDANCE POLICY:**

1. The referring court/agency, etc requires you to attend the entire program. You may not leave the premises at any time during the program. To fulfill your requirements the program must be **72 consecutive hours. Thursday 6 p.m. – Sunday 6 p.m.**

You must be at the program on **Thursday between 5:30 and 6:00 PM** in order to complete the 72 hours. The program begins promptly at 6:00 PM. **The program ends on Sunday at 6:00 p.m** Tardiness can be considered non-compliant as is leaving the program early and you will be returned to court.

There is a \$30.00 **non-refundable** registration fee. This fee is included in the \$400.00 cost of the class. Please inquire about the cost if you are eligible for SSI, Disability or Medicaid – you must provide valid documentation. The \$30.00 is a registration fee and is still non-refundable.

4. Absence from the program is excusable ONLY in extreme emergency situations, such as death in the immediate family, or a sudden illness or hospitalization. It is your responsibility to contact LARC's office during business hours, should any of these situations arise. At the time of your call, a determination will be made as to further disposition of your case. If you are excused from the class, you will be informed of the "**PROOF OF EMERGENCY**" that must be furnished prior to rescheduling your class. Work related problems **ARE NOT** acceptable excuses for nonattendance.

**Should you need to reschedule or cancel after a class date has been assigned, there is a \$100 cancellation/rescheduling fee.**

5. Arranging transportation to the program and working out conflicts in work schedules is the sole responsibility of participants.

6. Attendance in the program while under the influence of alcohol or other drugs is not permitted. Individuals who are disruptive or who behave in a manner that suggests they are under the influence of alcohol or drugs will be dismissed and will not be given credit for attendance. The court will subsequently be notified. The registration fee **WILL NOT** be refunded and an additional charge will be applied.

7. If after the screening at registration, LARC's personnel determine that you are too ill to participate, we may send you home and credit your payment towards the next available class. There is NO rescheduling fee charged to you in this instance.

8. **NO OTHER VISITORS WILL BE PERMITTED** during the weekend you are attending class.

9. You may **not** receive phone calls during the program. You will be permitted to make phone calls from the hotel pay phones or your cell phone during your free time and at the discretion of LARC staff. (TRUE emergency calls may be directed to the hotel. These calls will be screened by LARC staff and directed to you). You are not permitted to use your room phone for any outside calls – regular or long distance.

**ACCOMMODATIONS:**

1. The program is conducted at the **HAMPTON INN**, Route 45 and I-90 Austinburg. (2900 G. H. Drive) Located behind waffle house/McDonalds
2. You will share a room with another person. A private room is available for an extra cost and only if available. This option is not available if you are attending under a reduced rate.
3. All rooms are **NO SMOKING/NO VAPING** rooms. **The AWARE program DOES NOT permit vaping.** There will be designated smoke breaks for regular smokers. There is no smoking during sessions or in any of the hotel meeting rooms. Smokers need to plan accordingly.
4. Meals will be provided at 8:00am, 12:00pm, and 5:00pm. Special diets can be accommodated if you have indicated such a need on your medical/health history form. Please remind the staff of any special diet request when you arrive for class on Thursday night. **An evening meal on Thursday and Sunday will NOT be provided.** Coffee is provided throughout the entire program.

**WHAT TO BRING:**

1. Casual comfortable clothing – enough for at least **three** changes; low-heeled, comfortable shoes.
2. Sleeping clothes – robe, slippers.
3. Personal grooming supplies.
4. **Prescribed medication:** These should be listed on your health history. All medicines must be presented to LARC staff during the intake process. **NOTE: (BRING ONLY ENOUGH MEDICATION FOR THE TIME YOU WILL BE AT THE PROGRAM and THEY MUST BE IN THE PRESCRIBED BOTTLE WITH THE PHYSICIAN’S NAME AND DOSAGE).**

**Over-the-counter medication:** please again, only bring what you think you may need for the weekend. We also have some OTC items for your use.

**\*\* ALL MEDICATIONS NEED TO BE COUNTED AND THEREFORE; BRINGING FULL BOTTLES IS NOT RECOMMENDED**

5. Although there are snacks available at the front area of the hotel, you are permitted to bring your own snack food such as chips, pop, etc., refrigerators and microwaves are in every room **YOU ARE NOT PERMITTED TO ORDER OUT FOR FOOD DELIVERY.**
6. Cell phone policy – you are now permitted to bring a cell phone to the AWARE program. All rules must be obeyed.

**WHAT NOT TO BRING:**

1. Alcohol or other drugs – possession of which will result in immediate discharge and your being returned to court.
2. Any item you feel is of important value, such as jewelry, expensive radios, etc. **We will assume no responsibility for loss of property during the program.**
3. Large sums of money will not be needed.

**FINAL NOTE:**

The cost of the class is \$400.00 or if you are on Medicaid, SSI, or SS Disability, please inquire about the current cost. You are not scheduled for a class until paid in full. A payment is required every thirty days. If a time limit for registration for a class is not stipulated by the court, LARC will give you four months from your court date to pay in full and schedule a class date. Failure to comply with the “four month” time frame and/or not making monthly payments will result in your case being returned to court.

This program is not designed to punish. Rather, it is made available by area courts to provide people with relevant information about substance abuse and driving, in addition to insight into personal behavior, so that future offenses of this type can be avoided.

**I have read (or had read to me) this document. I have had an opportunity to ask questions. I understand and agree to abide by the terms of this agreement.**

**I acknowledge that I have received information pertaining to Clients Rights, Grievance Procedures, the Educational Curriculum for AWARE, Program rules and expectations, and a summary of the Federal Laws/Regulations regarding Confidentiality of Client Rights as protected by 42CFR Part B, Paragraph 2.22 and a copy of the Lake Area Recovery Center’s Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA).**

\_\_\_\_\_  
**Participant’s Signature**

\_\_\_\_\_  
**Date**

## AWARE HEALTH INFORMATION

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX M  F   
(PRINT)

1. Do you have a family or personal doctor? Yes  No  Name of Dr. \_\_\_\_\_ City \_\_\_\_\_

2. In the event of accident or illness, I authorize LARC to contact the above named physician.  Yes  No

3. Do you consider your health to be generally  Good  Fair  Poor

If Fair or Poor, explain \_\_\_\_\_

4. Do you have any medical conditions that may interfere with your participation in this program?  Yes  No

If Yes, please explain \_\_\_\_\_

5. Are you being treated for any serious medical conditions?  Yes  No

If Yes, explain \_\_\_\_\_

6. Do you take any medications (prescribed or OTC) \_\_\_\_\_

Do any require special handling? (Refrigeration etc.)  Yes  No

If Yes, explain. \_\_\_\_\_

7. Do you have any hearing or vision problems that will interfere with your ability to participate actively in the program?

Yes  No If Yes, explain \_\_\_\_\_

8. Do you have any drug, food or other allergies?  Yes  No If Yes, explain \_\_\_\_\_

\_\_\_\_\_

9. Do you have any special diet requirements? If Yes, please explain. \_\_\_\_\_

\_\_\_\_\_

10. Was this diet prescribed by a doctor? Yes  No

11. Is there anything else we should know about your health history?  Yes  No

If Yes, explain. \_\_\_\_\_

12. Have you ever experienced withdrawal symptoms when you stopped using alcohol or other drugs?  Yes  No

If Yes, explain. \_\_\_\_\_

13. Are you pregnant? Yes  No

14. Are you a smoker? Yes  No

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_ in the event we have questions about your medical needs

Staff Signature: \_\_\_\_\_