ADAPTED DRIVER EVALUATION
INFORMATION + APPLICATION

ALPHAONE
DISABILITY + AGING SOLUTIONS

Who benefits from an Adapted Driver Evaluation?

Our driver evaluation is designed to help people resume driving following onset of a disability or to help young adults with disabilities begin driving.

Who conducts Adapted Driver Evaluations?

Our staff has dually licensed Occupational Therapists and Driver Educators in the state of Maine. We function as professional consultants to Maine's Bureau of Motor Vehicles by providing recommendations for:

- Adaptive driving equipment
- Driver education and/or training
- Instructional techniques that will improve a student's learning and performance

Where are Adapted Driver Evaluations located?

Driver evaluations are held in our South Portland office. We will send you directions along with an appointment confirmation once we have received your completed application.

How long does the Adapted Driver Evaluation take to complete?

The evaluation generally lasts 3 to 4 hours.

What do I need to bring?

- Your driver's license or permit (if you have one)
- Your prescriptive glasses
- Documentation from your optometrist or ophthalmologist (if you have seen one within the last year)
- If you have a vehicle, please bring it to your appointment so the evaluator can look at it if needed

Will I be driving during the Adapted Driver Evaluation?

Yes! Please come prepared to drive during the evaluation. You will be driving one of Alpha One's driver evaluation vehicles in either an off-road or on-road course. Where applicable, you will be using adaptive driving equipment.

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Application Packet Instructions

- **Driver Evaluation Application Form** – Please complete *all areas* on this application.
- **Driver Evaluation Release Form** – Please complete and sign.
- **Alpha One Privacy Notice** – Keep for your records.
- **Alpha One Consent Form** – Please complete and sign.
- **Dear Physician and State of Maine Driver Medical Evaluation (3 pages)** – This form is shared by the State of Maine and Alpha One. Send this form to your physician to complete and return to Alpha One.

  The State of Maine requires all drivers to report any disability that may interfere with motor vehicle operation. We will send this form to the BMV along with our documentation. This will fulfill your legal reporting requirements to the BMV.

- **Driver Evaluation Service Authorization** – Alpha One is a private, non-profit business, and the driver evaluation fee is $500.

  - Driving is not considered 'medically necessary' by traditional health insurances. MaineCare and Medicare will not cover this service. The Veteran's Administration, Vocational Rehabilitation, Worker's Compensation, employers, and schools that provide driver's education for their students are all potential funding sources for this service. Payment for a driver's evaluation may be considered a medical or disability-related expense for income tax reporting or in determining rental subsidy.
  - **If you are paying privately, payment is due at the time of service. Personal checks, money orders, Visa, MasterCard, or cash are accepted.**
  - We do believe that our driver evaluation service is an excellent value for the dollar. During this time, you will be meeting with Occupational Therapists/Driver Educators who are also experts in Independent Living and Assistive Technology. You may find that we are able to point you in the direction of other resources that will enable you to live more independently in your community.

We are not able to schedule your driver evaluation appointment until we have received all necessary paperwork. The faster you complete this, the faster we can schedule your appointment.

We appreciate your interest in our driver evaluation and look forward to meeting with you in the near future.

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Driver Evaluation Application Form

Thank you for your interest in Alpha One's Adapted Driver Evaluation Program. In order to schedule an appointment, you must complete the following:

- Complete the attached application and return to the South Portland office via mail, fax, or email. Please include payment information requested at the bottom of this page.
- Sign the section "Authorization for Release of Medical Information" on the enclosed BMV Driver Medical Evaluation form, then forward to your physician for completion. Once completed, your doctor should send this form to our South Portland office.

Once we receive these forms, we will call you to set an appointment for the adapted driver evaluation and to verify payment for the service. Please call us at **800-640-7200 (v/tty)** if you have any questions.

Name_____ **Social Security #**_____

Address_____ **Date of Birth**_____

_____ **Age**_____

Phone_____ **Email**_____

Disability_____ **Date of Onset**_____

I am my own guardian. ☐ Yes ☐ No

Describe mobility equipment you use:_____

Physician Name_____ **Phone**_____

Address_____

Driver's License Number_____ **Exp. Date**_____

Restrictions_____ **Yrs. driving experience**_____

Have you ever had any driving violations? ☐ Yes ☐ No

If yes, please describe:_____

Do you own a vehicle? ☐ Yes ☐ No **If not, do you plan to purchase a vehicle?** ☐ Yes ☐ No

Make_____ Model_____ Year_____

Driver's Ed ☐ Yes ☐ No **Defensive Driving** ☐ Yes ☐ No

How will you pay for the evaluation?

☐ Self-Pay ☐ Special Education ☐ Voc Rehab Counselor (Name)_____
☐ Worker's Comp (Name)_____ ☐ Veteran's Benefits (Name)_____
☐ Other (Name)_____

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Privacy Notice

This notice describes how medical information about you may be used and disclosed. It also explains how you can access this information. Please review it carefully.

We understand that privacy is a very important matter. Our work requires us to gather your personal health information (PHI) in order to provide services. We create a record of the services that you receive and you can trust us to keep your records confidential and secure.

Collecting Information: We collect personal health and insurance information about you in order to provide you with services. Under state and federal law we are required to protect the privacy of your personal health information (PHI).

Confidentiality and Security: We restrict access to your PHI only to employees who need the information to provide you with services. We maintain physical, electronic, and procedural safeguards to comply with all laws and regulations to protect the privacy of your PHI.

Information Use: We do not sell your PHI to outside mailing lists or telemarketing companies. We will contact you to schedule appointments or discuss services via the telephone, email, or postal mail. You can specify the way you want us to communicate if it is necessary to protect your interests.

Information Disclosure: We use and disclose your PHI so that our staff can provide you with services and/or treatment, to obtain payment, and to perform service delivery operations (TPO). We review your PHI so that we can determine your program eligibility and sources of funding. The PHI that is disclosed may include: your name, address, social security number, phone number, diagnosis and disability, the name of your insurance provider, the insurance policy and coverage, reports/contact notes, and co-payments.

Any other use or disclosure of your information (for non-TPO purposes as described above) will require your written authorization. If you end your business with us, we will continue to restrict use of your personal health information as if you were still a consumer.

Your Rights: You have the right to restrict our use of your personal health information, to review and copy your record information, to request changes to your information, to find out who we have disclosed your information to, and to file a complaint about our privacy practices. If you file a complaint, we will take no action against you or change your services in any way.

To file a written privacy complaint, contact:

Tom Newman
P.O. Box 1870
Portland, ME 04104
800-640-7200 (v/tty)

We reserve the right to amend this notice at any time.

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Consent Form

For the use and disclosure of personal health information (PHI) for treatment, payment, or health care operations.

I hereby consent to the use and disclosure of my personal health information (PHI) by Alpha One to carry out services/treatment, payment, or health care operations. I have reviewed Alpha One's Privacy Notice and have a copy of that notice.

I have the right to request that the use and disclosure of my PHI be limited for only services/treatment, payment, and operations. I can revoke this Consent at any time by written request. I understand that Alpha One may refuse to provide me with services id I do not sign this Consent.

I have received and understand this information. I have received a copy of this form and agree to the stated terms.

Date_____ **Time**_____ **AM/PM**

Consumer Name (Printed)_____

Consumer/Representative Signature_____

Personal Representative_____

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DRIVER EVALUATION RELEASE FORM

AUTHORIZATION FOR RELEASE OF RECORDS

I, _____, hereby authorize the agencies and/or individuals listed below to release to Alpha One any and all records as requested.

Type	Name	Address (Street, City, Zip)
Bureau of Motor Vehicles	Medical Review Coord.	Station #29, Augusta, ME 04333
Physician/Medical	_____	_____

Other_____

_____

Signature_____Date_____

Witness_____Date_____

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Dear Physician,

Your patient has contacted us for a driving evaluation. We are authorized to use the State Driver Medical Evaluation form. Please complete this form and return it to Alpha One via mail or fax at:

Alpha One
Driver Evaluation Program
P.O. Box 1870
Portland, ME 04104
Fax: 207-799-8346

Questions may be addressed by calling 800-640-7200 (v/tty). A copy of the Functional Ability Profiles manual is available through the Bureau of Motor Vehicles or by visiting this web address:

https://www.maine.gov/sos/bmv/licenses/medical.html

Thank you.

State of Maine
Bureau of Motor Vehicles

DRIVER MEDICAL EVALUATION

THIS SECTION TO BE COMPLETED BY DRIVER (Please print) ***FOR QUESTIONS call*** *(207)624-9000, ext. 52124*

Name _____ Date of Birth _____

Address _____ License/History Number _____

_____ Telephone _____

INFORMATION BELOW TO BE COMPLETED BY APPROPRIATE MEDICAL OR PARAMEDICAL PROFESSIONAL

1. **Reason for Report**: To provide information to the Secretary of State regarding a possible physical, emotional or mental condition which could affect the driver's ability to safely operate a motor vehicle. **Your report will be advisory** and used to assist in determining eligibility for a driver's license.
2. **A Clinician Acting In Good Faith Is Immune** from damages claimed as a result of filing a Driver Medical Evaluation pursuant to 29-A MRSA Section 1258 (6). *The driver's signature is not required to submit this form.*
3. **Please Refer To Functional Ability Profiles (FAP)** to assist you in completing this form. The rules are available at, http://www.maine.gov/sos/bmv/licenses/medical.html. Please **provide Profile Level(s)** for specified condition(s) or any other condition that may affect the driver's ability to safely operate a motor vehicle.
4. **If You Have Any Questions** please call the Bureau of Motor Vehicles, Medical Section, at (207)624-9000, ext. 52124, or access the website; http://www.maine.gov/sos/bmv/licenses/medical.html

DIAGNOSIS THIS SECTION MUST BE COMPLETED – PLEASE PRINT OR TYPE	***FAP PROFILE LEVEL*** CHECK **ONE** BOX PER DIAGNOSIS				
	1	**2**	**3A**	**3B**	**3C**
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

NOTE: For any ***Alteration/Loss of Consciousness***, ***Seizure***, ***Stroke***, or ***Hypoglycemia episode requiring 3rd party intervention***, please give date(s) and describe most recent episode(s)_____

For ***Chronic Respiratory Disease***, please provide oxygen saturation and indicate if measured while using oxygen or not.
*O2 Saturation*_____ ☐ *On room air* ☐ *On oxygen*

For ***Hypoglycemia profile level 3b***, please check appropriate sub-category. ☐ 3b.i. ☐ 3b.ii.

For ***Prescription Medications and/or Opioid Replacement Therapy*** and patient meets criteria for profile level 3c, please check appropriate profile level sub-category. ☐ 3c.i. ☐ 3c.ii.

For ***Substance Abuse*** profile level 3b, please document how long the patient has been substance free. _____

CLINICIAN COMMENTS
(Please document if you are recommending restrictions, road test, or suspension of license, and describe deficits or impairments with potential to affect safe driving. Attach additional documentation if needed.)

Please proceed to next page…

MEDICATIONS currently prescribed: (may attach med list)

Reliability in taking medications

☐ Good ☐ Fair ☐ Poor ☐ Unknown ☐ No medication prescribed

Has patient reported or demonstrated any side effects from current medication(s) which would interfere with safe operation of a motor vehicle? ☐ NO ☐ YES, please describe_____

CERTIFICATE OF EXAMINATION (May be submitted without the patient signature)

Being duly licensed to practice in the state of _____ I hereby certify that I have examined this applicant.

_____ _____

(Clinician's signature) *(Degree & Specialty)*

_____ _____

(Clinician's name printed or typed) *(Address)*

_____ _____

(Office phone number) *(Office fax number)*

_____ _____

PROVIDE DATE OF LAST ASSESSMENT *(Signature Date)*

(Must be within past 12 months or as specified by BMV)

Reply to: *Bureau of Motor Vehicles, Medical Section*
29 State House Station
Augusta, Maine 04333-0029
Telephone: (207)624-9000 ext. 52124
E-mail: medical.bmv@maine.gov
Fax: (207) 624-9319

For assistance or to get a copy of the Functional Ability Profile rules, please go to:
http://www.maine.gov/sos/bmv/licenses/medical.html or
Call the Medical Section at (207)624-9000, 52124.

DRIVER AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical history by _____ to the Secretary of State, Bureau of Motor Vehicles. I understand that this information may be shared with any qualified health care professional submitting information pertaining to the disclosed medical history for the purpose of determining my eligibility for a driver's license.

PATIENT SIGNATURE _____ ***DATE***_____

E-MAIL _____ ***PHONE NUMBER***_____

FOR QUESTIONS OR CONCERNS, call (207)624-9000, ext. 52124, or access the website:
http://www.maine.gov/sos/bmv/licenses/medical.html

Veterans please visit the Bureau of Veterans' Services website at http://www.maine.gov/veterans for information on state and federal benefits your military service may have earned you.

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Driver Evaluation Service Authorization

Service To: _____
_____
_____

Billed To: _____
_____
_____

Fee: $500	**Description of Service:** Pre-road test screening of cognitive, perceptual motor skills; On-road testing of skills and learning potential for safe driving; Written report with recommendations to reimbursing agency, BMV, and the consumer.

Consumer Signature_____ Date_____

Authorized Purchaser Signature_____ Date_____