alphaOne

Redefining Disability

Adapted Driver Evaluation Packet

About the program:

Our driver evaluation is designed:

- To help people resume driving following onset of a disability
- To help young adults with disabilities start driving

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

Driver evaluations are held in our South Portland office and we will send you directions along with an appointment confirmation once we have received all necessary information from you.

The evaluation generally lasts 3-4 hours.
Please 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.

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

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 requirement 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 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 you for a driver's 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's evaluation and look forward to meeting with you in the near future.

tel | 800.640.7200
fax | 207.799.8346

alphaOne
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127 Main Street
South Portland, ME 04106

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. Please include payment information requested on page 1.
- 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 the 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 **1-800-640-7200(v/tty)** if you have any questions.

Name: _____ **Social Security #:** _____

Address: _____ **Date of Birth:** _____

Age: _____

Phone: ( ) _____ **E-mail:** _____

Description of Disability: _____ **Date of Onset:** _____

I am my own guardian. ☐ Yes ☐ No

Describe mobility equipment you use: _____

Physician Name: _____ **Phone:** ( ) _____

Address: _____

Driver's License Number: _____ State: _____ **Exp. Date:** _____

Restrictions: _____ Years 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: _____

☐ Two Door ☐ Four Door ☐ Minivan ☐ Van

Driver's Ed ☐ Yes ☐ No

Defensive Driving ☐ Yes ☐ No **AAA/55 Alive** _____

How will you pay for the evaluation?

☐ Self-Pay ☐ Special Education

☐ Vocational Rehab Counselor *Name:* _____ ☐ Worker's Comp *Name:* _____

☐ Veteran's Benefits *Name:* _____ ☐ Other *Name:* _____

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Alpha One – 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, e-mail, 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
127 Main St.
South Portland ME 04106
1-800-640-7200 (v/tty)

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

tel | 800.640.7200
fax | 207.799.8346

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South Portland, ME 04106

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 in order 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 if 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: _____

tel | 800.640.7200
fax | 207.799.8346

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South Portland, ME 04106

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.

	Name	**Address** *(Street, City, Zip)*
Bureau of Motor Vehicles	Medical Review Coord.	Station #29 Augusta, ME 04333
Physican/Medical		
Other		

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

tel | 800.640.7200
fax | 207.799.8346

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127 Main Street
South Portland, ME 04106

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
Driver Evaluation Program
127 Main St.
South Portland, ME 04106

Questions may be addressed by calling **207-799-2189 (v/tty)** or **1-800-7200 (v/tty)**.
A copy of the Functional Ability Profiles manual is available through the Division of Motor Vehicles.
Thank you.

State of Maine
Bureau of Motor Vehicles
DRIVER MEDICAL EVALUATION

THIS SECTION TO BE COMPLETED BY DRIVER (Please print)

Name _____ Date of Birth _____

Address _____ License/History Number _____

_____ Telephone _____

TO BE COMPLETED BY APPROPRIATE MEDICAL OR PARAMEDICAL PROFESSIONAL (Clinician)

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: If completing for ***Seizures***, ***Stroke***, or other ***Alteration/Loss of Consciousness***, please describe and give date(s) for most recent episode(s). _____

For ***Chronic Pulmonary Disease***, please provide oxygen saturation and indicate if measured while using oxygen or not.
O2 Saturation _____ ☐ *Without oxygen* ☐ *On oxygen*

For ***Hypoglycemia requiring 3rd party intervention***, please give date of most recent episode. _____
☐ Check here if patient has ***Hypoglycemic Unawareness***.

If completing this form for ***Opioid Replacement Therapy/Prescription Medications*** and patient meets criteria for profile level 3c, please provide sub-category. (3c-i *or* 3c-ii) _____

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

CLINICIAN COMMENTS
(Please 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 ☐ If 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)*

_____ **DATE OF LAST EXAM**
(Must be within past year or as specified by BMV)

_____ *(Signature Date)*

Reply to: *Bureau of Motor Vehicles, Medical Section*
29 State House Station
Augusta, Maine 04333-0029
Telephone (207)624-9000 ext. 52124
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.

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 _____ ***PHONE NUMBER*** _____
DATE _____

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

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Driver Evaluation Service Authorization

Service To: _____

_____

_____

Bill To: _____

_____

_____

Alpha One Worker:	
Fee: $500.00	Authorization Date:
Projected Number of Hours:	Service Start Date:

Services Authorized	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:** _____