MIKE LINK DRIVER INTERVENTION PROGRAM REGISTRATION FORM 2024

PROGRAM DATE YOU WISH TO ATTEND: Please check one ***(If left blank, you will be placed in the next available program)***

☐ **February 1st – 4th, 2024** ☐ **April 4th – 7th, 2024**

☐ **August 15th – 18th, 2024** ☐ **October 10th – 13th, 2024**

The Mike Link Driver Intervention Program is a 72- hour driver intervention program.

- To be ***FULLY*** registered, payment must be included with this registration form. Registration deadline is the Friday before the week of the program or when program is full. Call to check on program status.
- Registration is $375.00, $475.00 single room (military discount $356.25/ $451.25 single, and must be paid at the office).
- **Registration fees are non-refundable unless cancelation is made no less than 10 days prior to the first day of the Driver Intervention Program.**
- You may register and pay on line at www.lgrc.us.
- Or you may send ***cashier's check or money order (payable to Lake-Geauga Recovery Centers)*** with registration form to the:

Lake-Geauga Recovery Centers, Attn: Driver Intervention Program
209 Center Street, Suite E, Chardon, Ohio 44024

- Or ***credit card*** in person at any of our outpatient offices (9083 Mentor Ave, Mentor; 134 S. St. Clair, Painesville; 209 Center St., Chardon) from 9:00 AM – 4:00 PM Monday through Thursday and 9:00 AM – 3:00 PM Friday. Please call in advance to check for holidays or office closings.
- No cash or personal checks will be accepted.
- If applicable, you must bring proof of: **Ohio Medicaid card, SSI or SSDI benefit letter, TANF card, letter from Public Defender or Judge verifying your indigent status within the past 30 days** in person to the above address.
- **ACTIVE SOLDIER & FAMILIES OF DEPLOYED SOLDIERS:** Military personnel and their immediate families will be offered a 5% discount off the cost. Please bring a military ID, photo, or proof of military status and relationship to the military personnel to the office.
- Upon receipt of your registration and fee, a confirmation letter containing program date, instructions, complete rules, and a map will be sent to you. At this time, you will be a client and we will only speak to you; if you call as per the Privacy Rule below.
- If you do not receive a packet within 14 days of sending your registration, it is your responsibility to notify the Lake-Geauga Recovery Centers. Call 440-255-0678 if you have any questions.

PROGRAM RULES

1. This program is held at a camp facility & you are housed in cabins with heat. Personal bedding and outdoor clothing are required. Additional information will be included on your confirmation letter.
2. Each participant must remain on the premises, in designated areas, and drug and alcohol free during the entire duration of the program.
3. We reserve the right to search your luggage or sleeping accommodations at any time if you are suspected of being in possession of alcohol or other drugs. If you require over-the-counter or prescription medications, you must be certain that your medication/prescription bottle is in its original container, clearly marked with your name, the prescribed dosage, the exact number of pills for the weekend, and the name and phone number of the prescribing physician. Medication will be kept locked by staff and you may have access to it throughout the weekend accordingly.
4. Personal phone calls or visits are not permitted. Staff will evaluate emergency calls.
5. Please leave valuables at home. ***Cell phones***, computers, playing cards, tape recorders, radios, TV's and musical instruments are not permitted and may result in your immediate dismissal from the program.
6. No tardiness, theft, gambling, threats of personal harm, any form of unacceptable behavior, roughhousing, or displays of affection (example: holding hands, kissing, physical contact) will be tolerated and may result in your immediate dismissal from the program.
7. NOTE: If you appear to be under the influence of alcohol or any other mood altering chemical, you will be requested to take an "instant test". If it is determined that you are under the influence, your registration fee will not be refunded. You will not be admitted into the program or allowed to stay for the remainder of the program, or be re-scheduled.
8. The confirmation letter will automatically be sent to the address listed and in case of cancellation or other necessary changes to the program, we will contact you.
9. You are expected to participate in all aspects of the program and complete all assignments.

(PLEASE COMPLETE THE REVERSE SIDE)

Program Assigned:

Please read and fully complete the registration form below.

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

HOME PHONE: (_____) _____CELL PHONE: (_____) _____

DATE OF BIRTH: _____/_____/_____ GENDER: ❒Male ❒Female SSI#_____

REFERRING COURT: _____ JUDGE: _____

COURT ADDRESS: _____CITY:_____STATE:_____ZIP:_____

PROBATION OFFICER: _____TYPE OF PROBATION: _____PROBATION ENDS: _____
(reporting or non-reporting) (if reporting)

OFFENSE: _____ARREST DATE: _____CASE NUMBER: _____

B.A.C.: •_____ TYPE OF TEST: BREATH_____URINE_____BLOOD_____ OTHER_____REFUSED_____
(Blood alcohol concentration)

ATTORNEY'S NAME: _____

EMERGENCY CONTACT: _____ _____ _____
Name Phone Number Relationship to DIP Participant

_____
Street Address City State Zip

DO YOU HAVE ANY SPECIAL DIETARY REQUIREMENTS? If yes, list: ☐ **Yes** ☐ **No**

_____

DO YOU HAVE ANY FOOD ALLERGIES OR REACTIONS? List Food and Reaction ☐ **Yes** ☐ **No**

_____

ARE YOU CURRENLTY PREGNANT? If yes, approximate due date: ☐**Yes** ☐ **No**

_____

DO YOU HAVE ANY OTHER SPECIAL NEEDS?(Physical/communication impairments, If yes, list needs)☐ **Yes** ☐ **No**

_____

CONFIDENTIALITY/PRIVACY RULE

I understand that my records are protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Drug abuse patient records are also protected under the Health Insurance Portability Act of 1996 (HIPAA), 45 C.F.R., parts 160 and 164. The HIPAA Privacy rule provides individuals the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The Privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by an individual.

CORRESPONDENCE

I wish to be contacted in the following manner:

☐ Contact me at the following number(s) _____ for registration information in the event we need to check information on the registration form.

I, THE UNDERSIGNED, HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE RULES AND CERTIFY THAT ALL INFORMATION CONTAINED IN THIS FORM IS TRUE AND ACCURATE

_____ _____
Client signature **Date**

I AUTHORIZE VERIFICATION OF MY REGISTRATION TO THE REFERRING COURT

_____ _____
Client signature **Date**

Interoffice Only: Paid $ _____ by □ MO □ Cashier Check □ Other _____ Receipt # _____
Confirmation was □ sent by mail □ given in person at office □ Program rescheduled to _____ & confirmation sent