Guidelines/Instructions for Out of State DWI Transfer Cases

Details of Transfer Packet by page:

Page 1 – Guidelines/Instructions for Out of State DWI Transfer Cases

- A Completed File Needs to Have (See check list at the bottom of this page)

Page 2 – Client information-You fill out and return to Court Services @ Anuvia or call and give information over phone

Page 3 – Outline of North Carolina Minimum Requirements: To be given to counselor.

Page 4 – Completion Form for Relicensing: To be filled out by counselor.

Page 5 – Authorization for Release/Exchange: You need to fill this out with the name of your counselor and agency so that we may contact them. Sign and date with a witness and return to Court Services @ Anuvia.

Page 6 – Fill out this page **ONLY** if someone other than yourself will be calling/asking about your case. You need to sign and date with a witness and return to Court Services @ Anuvia.

Page 7 – Authorization for DMV: So we can send your paperwork to the DMV once your file is completed. Print name and date of birth at the top of the page and sign and date the bottom of page with a witness and return to Court Services @ Anuvia.

Page 8 – Request for Status: You need to mail this form off with $130 to the address in bold at the top of the page.

Page 9 – Suggested Agencies & DMV Contact: Agencies to contact in your state if needed and DMV information to obtain Driving History from current state

CHECKLIST - A COMPLETED FILE NEEDS TO HAVE:

☐ Have your agency contact Anuvia's Court Services department before making a recommendation.

☐ **$160 transfer fee in the form of Money Order, Certified Check, or Credit/Debit can be taken over the phone ($160 for each additional DWI) Please make payable to the Anuvia. Payments can be made on request.** *Please note once services are rendered there is no possibility of refunds.

☐ **Releases** - Agency/Person Release (page 5) and NC DMV Release (page 7) *If you want us to be able to speak with a family member or friend about your case you will need to fill out page 6 naming the individual we can speak to.

☐ Completion Form for Relicensing. **Page 4** -Your counselor needs to complete this form, have it notarized, and send it back to Court Services @ Anuvia. **The following is the information contained on the Completion Form for Relicensing:**

- ☐ Current DWI Substance Abuse Assessment. You will need to begin a program within 6 months of your assessment date or a new SA assessment will be required per DWI Services policies and procedures.
- ☐ Education/Treatment program completion

☐ Driving Record from your current state of residency.

Comments: ____________________

____

____

Keep For Your Records

Client Information

Name: First ________________ Middle: ______________ Last: ______________ Maiden:_____________

SSN: _____________ Sex: ☐Male ☐Female Date of Birth: ________ License #: _____________ State: ____

Address:____

City, State, & Zip: _____________________ Home Phone: ______________ Cell Phone: ______________

Employment Status: ☐Student ☐Unemployed ☐Full Time ☐Part Time ☐Retired ☐Disabled ☐Other

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐Co-habitation

Language: ☐English ☐Spanish ☐Sign Language ☐French ☐Italian ☐German ☐Arabic ☐Vietnamese ☐Russian

Education: ☐8th Grade ☐9-12 Grade ☐High School Grad ☐Some College ☐College Grad ☐GED ☐Voc/Tech ☐Other

Ethnicity: ☐Latino or Hispanic ☐Non-Latino

Race: ☐African American ☐American Indian ☐Asian ☐White ☐Pacific Islander ☐Other

Living Arrangement: ☐Spouse/Partner ☐Parents ☐Relative, Non-parent ☐Adult, Non-relative ☐Child ☐Roommate ☐Alone ☐Nursing Home ☐Homeless ☐Group Home

Do you have medical insurance? ____________ **Name of company:** _______________________

If you **do not** know you NC license or customer number please call NC DMV at 919-715-7000 to provide us with this number. Have you ever been licensed in NC? _______ NC Customer Number: ________________________

Do you have any prior DWI or Consuming Underage Convictions (ever): ______________________________

Please fill out if you have the following information:

Offense County: ______________________ Offense Date: ___________ Conviction Date: _____________

Docket/File #: ______________ BAC (Blood Alcohol Content): _____

Fill out and return to Court Services at Anuvia or call us at 704-927-8840 to go over this information with us.

Outline of North Carolina Minimum Requirements for DWI

The named individual below has been ordered by the courts in North Carolina to complete a DWI Substance Abuse Assessment. The assessor must recommend the client take an education or treatment program that meets the North Carolina minimum requirements. The client must begin a program within 6 months of the assessment date or a new DWI SA assessment will be required per DWI Services policies and procedure. Since this individual is a resident of your state, the referral is being transferred to your state for compliance of the court order.

Minimum Requirements for a NC DWI

DWI Education (Alcohol & Drug Education Traffic School):

- First DUI/DWI conviction (lifetime)
- Arrest BAC or .14 or less
- Did not refuse breath test
- Has no substance abuse diagnosis
- Program must be a minimum of 16 contact hours completed in no less than 5 sessions.

DWI Short-term Treatment:

- Can be 1 or more than 1 DUI/DWI
- Refused breath test
- BAC of .15 or greater
- DSM-IV diagnosis of Substance Abuse
- Meets Level I ASAM (American Society of Addictions Medicine) program placement criteria.
- A minimum of 20 contact hours, minimum of 30 days

DWI Intermediate Level Treatment:

- Meets criteria for DSM-IV Substance Abuse Diagnosis Dependence
- Meets Level I ASAM program placement criteria
- Minimum of 40 contact hours, minimum 60 days

Intensive Outpatient Treatment:

- DSM-IV diagnosis of Substance Dependence moderate to severe
- Meets Level II ASAM program placement criteria
- A minimum of 90 contact hours, minimum 90 days
- According to ASAM, intensive outpatient requires at least 3 sessions and 9 hours per week in treatment

Inpatient / Residential Treatment:

- DSM – IV diagnosis of Substance Dependence, severe
- Meets Level III or IV placement criteria
- Upon discharge from inpatient treatment, a person has to enroll in an approved continuing care of outpatient program to meet the 90 day time frame

If you have any questions, please forward them to the Court Services department of Anuvia. Attn: Court Services, 100 Billingsley Rd Charlotte, NC 28211 704-927-8840(phone) 704-376-4570(fax)

Completion Form for Relicensing

This form must be completed in its entirety after all education and treatment requirements have been met. An incomplete form cannot be processed.

Date: ___________________________Name:____
Last Name First Name MI

Please note that Anuvia requires that the **assessment or final treatment must have occurred within six months of the date of this recommendation. Please include a discharge summary. Please call this office before making final recommendation to verify NC program requirements.**

Hours of Assessment: ___________ Date: _______________ Counselor or Facility: ________________________

Recommendation: ____

1. Hours of DUI/DWI Education/Instruction: _________ From: ____________ to __________________
   Date Date
   Counselor or Facility: ____

2. Hours of Individual Counseling: ___________ From: ____________ to ______________
   Date Date
   Counselor or Facility: ____

3. Hours of Outpatient Group Counseling: _________ From: ____________ to _________________
   Date Date
   Counselor or Facility: ____

4. Hours of:_____________________________________From: ____________ to ________________
   (Please specify other services) Date Date
   Counselor of Facility: ____

A Certified Addictions Counselor, Licensed Professional, or State Approved DUI/DWI Evaluator (not instructor) must complete this form. Individuals trained as a DUI/DWI instructor or other office personnel are not authorized to complete this form.
This is to certify that individual referenced above has completed services as outlined below in accordance with a clinical assessment and the requirements for successful completion of the licensed facility, during which time an acceptable DUI Risk Profile was demonstrated. Every reasonable effort will be made to ensure that the public's safety and the welfare of the individual will not be appreciably endangered by the reinstatement of driving privileges.

____
Signature of Person Completing Form Print Name Date

I further certify that I possess state and/or national certification, licensure, and/or other state credentials to provide assessment, diagnosis and referral services.

____
Licensure/Certification Please list in full (i.e. National Addictions Counselor) Personal Certificate Number (not program or agency #) Expiration Date

____
Agency Address Phone Number

Please Affix Notary Seal

____
Notary/Witness **Date**

This form is to be completed by your program counselor and returned to Court Services @ Anuvia.

AUTHORIZATION FOR THE RELEASE/ EXCHANGE OF INFORMATION

Client Name ______________________________ Client # _______

Person/Agency/Facility releasing/exchanging information:
(Include name and address)

____

____

I, ____________________, voluntarily authorize and request the release/exchange (including paper, oral and facsimile interchange) of the specified information between Anuvia and the above-named person/agency/facility.

This data shall include All of my substance use disorder records to include: Assessment, Diagnosis information, Results of urinalysis and breathalyzer readings, status and progress, attendance and compliance with treatment plan, prognosis, prescribed medications, medication compliance, recommendations, aftercare plan and referrals, and/or AIDS (acquired immune deficiency syndrome), AIDS related complex (ARC) HIV antibody testing/admission/discharge summary.

The purpose of the disclosure authorized in this is to Provide Information and Coordinate Services.

The doctrine of informed consent has been explained to me and I understand the contents to be released, and the need for the information. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Client Records, 42, C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that pursuant to 42, C.F.R. Part 2, I have a right to receive a list of entities to which my patient identifying Part 2 information has been disclosed. I also understand that I may revoke this consent in writing at any time except to the extent that reliance has been taken upon it (information that was released prior to this consent being revoked cannot be unrevealed). This consent expires automatically 365 days from the date of signature below, or at an earlier date or event specified: .

I understand that Anuvia may not condition my treatment on whether I sign a consent form.

____

Client Signature Date

____

Legal Guardian Date

____

Witness Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR 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 a person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

www.anuvia.org
Outpatient Services · 100 Billingsley Road · Charlotte, NC 28211 · Phone 704-376-7447 · Fax 704-376-3384
Detox and Residential Services · 429 Billingsley Road · Charlotte, NC 28211 · Phone 704-445-6900 · Fax 980-406-3608
Adolescent Services · 100 Billingsley Road · Charlotte, NC 28211 · Phone 980-321-5370 · Fax 980-321-5366

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(Include name and address)

____

____

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Legal Guardian Date

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Witness Date

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MECKLENBURG COUNTY DWI PROVIDERS ASSOCIATION RELEASE/EXCHANGE CONFIDENTIAL

Client Name ________________________________ Client DOB ______

By my signature below, I voluntarily authorize and request **Anuvia** to release and exchange information specified below (including paper, oral, and facsimile interchange) with the following parties:

_____ North Carolina Department of Mental Health, Developmental Disabilities and Substance Abuse Services
_____ North Carolina Division of Motor Vehicles
_____ North Carolina Department of Community Correction (Probation/Parole):
_____ Court of Jurisdiction:
_____ My Attorney Office of Record, as an Officer of the Court:
_____ North Carolina DWI Assessment Agency:

_____(client's initials) Information to be released / exchanged shall include results of the substance abuse clinical assessment; prior conviction and/or treatment; completion / non-completion of program recommended by this assessment; issues related to compliance with program rules; progress while in treatment; recommendations for continuing care; DSM diagnosis, assessment summary, BAC, Lab/UA results, and the Form 508R. Client should initial on the line provided.

I understand that this information will only be used in compliance with G.S. 20-17(m), 1987 Chapter 797, Senate Bill 508, as amended. I understand that verification of my compliance with the assessment, treatment, or education called for is necessary for my driver's license to be reinstated, and to comply with a court judgment, if so ordered by the presiding judge. In addition, this information is reported for the purpose of tracking, DWI intervention, and compliance.

The doctrine of informed consent has been explained to me and I understand the contents to be released, and the need for the information. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Client Records, 42, C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that 42 C.F.R. Part 2 prohibits re-disclosure of my records to a third party without my written consent.
I also understand that I may revoke this consent in writing at any time except to the extent that reliance has been taken upon it (information that was released prior to this consent being revoked cannot be unrevealed). This consent expires automatically 365 days from the date of signature below, or at an earlier date or event specified: .

____
Client Signature (Full Legal Name) Date

____
Legally Appointed Representative Date

____
Witness Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR 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 a person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revised C Costa 11/08 ER Coulthrust 10/11 D Lyman 6/16 H Drum 10/17

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REQUEST FOR STATUS REPORT (MVR)

NCDMV
Attention: Physical Unit

PO Box 29615

Raleigh NC 27626

Dear Sir:

Enclosed is my $130.00 restoration fee. Please send me a status report (MVR) so I can get my license in

_________________________.
(State you live in)

____
Full Legal Name

____
Correct Mailing Address

____
Date of Birth

____
NC Driver's License # or Customer #

Please mail this form with fee to the above address.

AGENCIES IN YOUR AREA

1. Agency Name: ______________________________

   Address: ______________________________

   City: ______________ State: _______ Zip Code: _________

   Telephone Number: ______________________________

2. Agency Name: ______________________________

   Address: ______________________________

   City: ______________ State: _______ Zip Code: _________

   Telephone Number: ______________________________

DMV Contact Information

Name: ______________________________

Address: ______________________________

City: ______________ State: _______ Zip Code: _________

Telephone Number: ______________________________

Keep for your records