2501 Dudley Avenue #7 Parkersburg, WV 26101 304-485-1721

COST OF THE SAFETY AND TREATMENT PROGRAM

Level 1

Enrollment, Orientation, Assessment, Classes, and Exit	**$400**
Workbook	**$20**
3 Urine Drug Screens 1st @ enrollment; 2 randomly during the course at 35.00 each	**$105**
Total	**$525**

Level II (all level 2 must complete level 1 requirements)

6 1-hr groups @ $40.00 per group	**$240**
TOTAL	**$765**

The DUI Dept contact, financial, release of information sheet for the DMV along with the Certified Driver Record and copy of ID are required prior to enrollment.
This does not obligate you in any way. It helps us be prepared to assist you.

The Enrollment and Book Charge are to be paid at the time of *Orientation*. The first of three Urine Drug Screens is required at the time of *Enrollment.* The balance may be paid at the time of Enrollment, or at the time of service, or at the end of the services.

2501 Dudley Ave #7 Parkersburg, WV 26101 304-485-1721
www.westbrookhealth.com

DUI STATE REPORT INFORMATION
NAME ON LICENSE:
PHONE NUMBER:
SOCIAL SECURITY #:
DATE OF BIRTH:
DRIVER LICENSE#: STATE ISSUED:
COUNTY OF RESIDENCE:
E-MAIL ADDRESS:
DATE OF PAYMENT:
INTERLOCK DEVICE: YES OR NO
MILITARY: YES OR NO CURRENT OR RETIRED? YES OR NO
SPOUSE IN MILITARY: YES OR NO CURRENT OR RETIRED?

COPAY: ____

WESTBROOK HEALTH SERVICES, INC. FINANCIAL DATA SHEET

☐ Update ☐ Fee Waiver (Charity Care)	☐ Intake – Clinician: ________________	
Date:	Client ID:	
Last Name:	First Name:	Middle Name:

Client
Date of Birth ____/____/____
Social Security Number ______-_____-______
Gender ☐ Male ☐ Female
☐ Identify as: ______________
☐ Prefer not to disclose

Race ______________________________
Marital Status ________________

If client is a minor, or is not their own guardian, please also fill out the information on the right.

Guardian Name ______________________
Relationship to client: ______________
Date of Birth ____/____/____
Social Security Number ______-_____-______
Address (if different):
____
City ____________ State _____ Zip _____

Home Address:
____
City: ________________ State: ________
County: ____________ Zip Code: __________
Months at this address: ________
May we send you mail? ☐ Yes ☐ No

Mailing Address (if different):
____
City: ________________ State: ________
County: ____________ Zip Code: __________
E-mail address: ______________________
May we e-mail you? ☐ Yes ☐ No

Telephone Number:	**Can we leave a voicemail?**	**What is your contact preference?**
Home: (_____)-______-______	☐ Yes ☐ No	☐ Call ☐ E-mail ☐ Text
Cell: (_____)-______-______	☐ Yes ☐ No	
Other: (_____)-______-______	☐ Yes ☐ No	

By checking these boxes, I consent to have service notifications, appointment reminders, and other notifications provided to me. I understand I have the right to revoke this consent, in writing at any time, and the revocation will be effective except to the extent that Westbrook Health Services or its staff has already taken action in reliance to my consent.

☐ Please check this box if you would NOT like to be called or receive text reminders at any phone number listed.

Family Doctor/Primary Care Physician:
Name: ______________________
Phone: (_____)-______-______

Emergency Contact Information:
Name ______________________
Relationship: ______________________
Phone: (_____)-______-______

Family Finance

Total number of IRS-defined dependents in household: ____

☒Self/Client How many: 1
☐Spouse/Guardian How many: ____
☐Dependents under 18 How many: ____
☐Dependents over 18 How many: ____

Family Monthly Income

Amount $__________ Type ______________
Amount $__________ Type ______________
Amount $__________ Type ______________

☐I am not interested in the Fee Waiver (Charity Care) and I prefer not to disclose my income.

WESTBROOK HEALTH SERVICES, INC. FINANCIAL DATA SHEET

Is this individual court-ordered or recommended by their attorney into treatment? ☐ Yes ☐ No
Were copies of available information regarding co-pay, co-insurance, and deductible provided? ☐ Yes ☐ No
Would you be interested in getting information about Westbrook's Primary Care Program? ☐ Yes ☐ No

Agreement and Understanding

1. **FINANCIAL AGREEMENT:** I CERTIFY THAT ALL OF THE INFORMATION CONTAINED IN THIS DOCUMENT IS CORRECT. I FURTHER CERTIFY THAT, IF PERTINENT OR MAY BECOME PERTINENT TO ME, I HAVE READ THE CHARITY CARE PORTION OF THIS DOCUMENT AND AGREE TO FOLLOW THESE REQUIREMENTS DURING THE DESIGNATED TIME OF TREATMENT. IF I DO NOT COMPLY WITH THE ABOVE REQUIREMENTS, I UNDERSTAND THAT I WILL NOT BE ELIGIBILE AND WILL NOT RECEIVE CHARITY CARE SERVICES.
2. **HANDOUT:** I CERTIFY THAT I HAVE BEEN OFFERED A COPY OF THE FINANCIAL/CHARITY CARE HANDOUT AND UNDERSTAND THAT I MAY ASK FOR A COPY AT ANY TIME IF I CHOSE NOT TO TAKE A COPY TODAY.
3. **PHOTOGRAPH:** I CONSENT TO ALLOWING WESTBROOK TO TAKE MY PICTURE FOR INCLUSION IN MY MEDICAL RECORD: ☐ Yes ☐ No
4. **I HAVE READ THESE AND HAVE BEEN PROVIDED AMPLE TIME TO ASK HAVE MY QUESTIONS FULLY ANSWERED. I HAVE SIGNED INDICATING MY UNDERSTANDING OF THE TERMS OF THIS FINANCIAL AGREEMENT AND FINANCIAL/CHARITY CARE HAND OUT, WHICH INCLUDES REFERENCES TO PAYMENT PLANS FOR UNPAID BALANCES PROCEDURES. I AGREE TO ABIDE BY ALL OF THEM.**

Consumer Signature Date

Guardian/Legal Representative Signature Date

Are you this individual's legal guardian? ☐ Yes ☐ No

Staff Signature Date

WESTBROOK HEALTH SERVICES, INC.
Consent to the Use and Disclose Health Information for Treatment, Payment, or Other Healthcare Operations *(Release of Information) v5*

I, ____________________________, Date of Birth: ______________, Social Security Number: __________

Hereby give my consent to Westbrook Health Services, Inc. and the organization specified below to release my health information to each other (reciprocally), as specified in this Consent.

Name of organization: WV Division of Motor Vehicles
Address: 5707 MacCorkle Ave., SE #400
City/State/Zip: Charleston, WV 25304
Telephone: 304-588-3900

I authorize the following information to be released (check all that apply):

- [x] Treatment status
- [x] Alcohol/Drug Treatment Summary
- [ ] Medical History/Treatment Sum.
- [x] Alcohol/drug use history
- [ ] Minimum Necessary Information for billing
- [x] Other (be specific): Interlock Program
- [ ] Consultation Reports
- [ ] Psychiatric History/Treatment Sum.
- [ ] Family/social History
- [ ] Waiver Packet Information
- [ ] Consultation Reports
- [ ] Cost of treatment
- [x] Services provided
- [x] Progress/Compliance report
- [x] Treatment Discharge summary
- [ ] Entire Treatment record
- [ ] Assessments/Evaluation Reports
- [x] Treatment Time Periods

I understand that the information to be released that I have checked above may include information about conditions listed below. I have checked each of the elements below indicating this understanding. Please check below as appropriate:

- [ ] Diagnoses and/or treatment for mental / behavioral health, alcohol and/or drug abuse
- [ ] AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment;
- [ ] HIV test results;
- [ ] Diagnoses and/or treatment relating to other communicable diseases

Except as limited (be specific): 400SE Form

This Consent for Use/Disclosure is for the following purpose:

- [x] Facilitate SA/MH/DD Treatment
- [ ] Legal action information
- [ ] Request of consumer
- [x] Other (be specific): Evaluate performance in WV DUI Safety & Treatment Program
- [x] Coordinate Care
- [ ] Referral for other treatment
- [ ] Verification, authorization, collection, appeal of benefits (insurance, etc.)
- [x] Abuse/Neglect reports
- [x] Treatment status update
- [ ] Probation/Parole compliance
- [ ] Obtain Benefits

This Consent will remain effective for [ ] 90 days [ ] 180 days [x] other date/condition/event: 365 Days

I understand that I have the right to revoke this Consent, in writing, at any time, and that the revocation will be effective except to the extent that Westbrook Health Services or its staff has already taken action in reliance on my consent. My written statement that I want to revoke my consent should be delivered to Medical Records at Westbrook Health Services, 2121 Seventh Street, Parkersburg, WV 26101.

I understand that as part of my healthcare, Westbrook Health Services, Inc. originates and maintains health records including my Protected Health Information (PHI) describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and medical information to my bill, a means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to receive and review the Notice of Privacy Practices prior to signing this Consent. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Westbrook Health Services, Inc. is not required to agree to the restrictions requested. I understand that my refusal to sign this Consent will not affect my ability to obtain treatment, payment, or enrollment in a health plan.

Signed: ____________________ Printed Name ____________________ Date __________

Witness: ____________________ Printed Name ____________________ Date: __________

If the signer is not the Individual, what Relationship and Authority does he/she have to act on behalf of this person: __________
Means used to identify the signer (Driver's License, Guardianship papers): ____________________

MH/I/DD: *"This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. Regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains."*
SA: *"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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug patient"*

WESTBROOK HEALTH SERVICES, INC.
TECHNOLOGY SERVICES USER AGREEMENT

Name: ____________________ **Staff ID:** ______________ **Date:** ______________
Department: ________________ **Site:** ______________ ☐ **Exempt** ☐ **Non-Exempt**

As an employee of Westbrook Health Services, Inc., **I RECOGNIZE AND UNDERSTAND** that E-mail and Internet/Intranet services are to be used for conducting agency business only and may only be accessed by using my assigned access code.

General Agreements (all staff):

______ INITIALS	**I UNDERSTAND** that use of these technologies for personal purposes is strictly restricted;
______ INITIALS	**I AGREE** to protect the privacy of the Westbrook and consumers (see Ethics and Confidentiality Agreement); **I AGREE** not to transmit any Confidential Electronic Data (Protected Health Information (PHI) and/or Individually Identifiable Health Information (IIHI)) using E-mail, Texting or Social Media and/or any Internet/Intranet network system unless I am authorized to do so by agency procedures and all applicable laws. **I UNDERSTAND** that Confidential Electronic Data (IIHI) is any information through which the identity of a consumer may be deduced by an outside party and that even if a message does not contain the consumer's name, it might still be possible for someone to identify the consumer. **I UNDERSTAND** that this prohibition also means that I must not E-mail or Text Confidential Electronic Data (IIHI) or PHI even over internal agency e-mail to other Westbrook staff except as permitted by state and federal law;
______ INITIALS	**I AGREE** to prevent malicious software (virus and other malware) infections through my E-mail and/or Internet/Intranet access. **I AGREE** to follow all preventative measures as detailed by IT Procedures or communicated to me by IT staff, including: using my provided virus checking software; not downloading any files from the internet without IT permission; and making sure the file types of any E-mail attachments I receive are safe before I open them, and so on. **I FURTHER AGREE** to report to IT any unusual computer activities or strange e-mails I receive as soon as possible;
______ INITIALS	**I TAKE RESPONSIBILITY** for the use of my Internet/Intranet account. **I AGREE** to never knowingly allow other persons to use my account or access the internet from my computer unless it is approved by their supervisor, and is for purposes permitted by Westbrook procedures;
______ INITIALS	**I UNDERSTAND** that Westbrook Health Services, Inc. reserves the right to access, review, and disclose to appropriate authorities, without prior notice or permission, any and all materials which are contained or stored on my work computer. The use of my work computer to retrieve personal messages or to save personal information is considered to be disclosing that information to Westbrook. **I AGREE** to give the agency access to any and all material on my work computer, at any time with or without my prior notification or permission, including at times when I am not present. **I AGREE** to disclose on demand, to my supervisor and the IT department, any non-agency assigned passwords needed to access E-mail and/or files on my work computer to provide such access;
______ INITIALS	**I ACCEPT** my access code as permission to access confidential patient information and medical records at Westbrook Health Services, Inc. **I UNDERSTAND** that my access code is confidential. I am not permitted to provide, post or otherwise release this access code. If I should provide, post or release this code, I am responsible for any consequences and may be subject to Westbrook's disciplinary procedures up to and including termination;
______ INITIALS	**I UNDERSTAND** and **AGREE** that I will never access private information of consumers, employees, agents, contractors or others at Westbrook Health Services by any means unless I have permission to do so. **I UNDERSTAND** that this includes information in any format, including but not limited to electronic, paper, video, audio or any other format.

Electronic Signature Attestation (only for staff who electronically sign documents):

______ INITIALS	**I ATTEST that I have placed on file at Westbrook Health Services, Inc. all holograph signatures for any signatures indicated by a "conformed" signature within an "efiled" document.** The original with the holograph (ink) signature will be kept by Westbrook for subsequent production, as required. **I FURTHER ATTEST** that the chosen method for electronic signature is under my sole control.

I CERTIFY by signing below:

1. I have read and I understand the Technology Services User Agreement and have indicated my understanding by writing my initials in the appropriate sections;
2. I have received training on Technology Services Usage Procedures and Privacy and Security Procedures (as promulgated under state and federal laws and rules) and will contact my immediate supervisor if I need additional training. If requested training is not provided, I agree to contact Administration at Westbrook Health Services, Inc.; and
3. I understand that violations of these procedures may subject me to disciplinary action, up to and including termination of employment.

____________________________ ____________________

EMPLOYEE SIGNATURE DATE

WESTBROOK HEALTH SERVICES
WV DUI SAFETY AND EDUCATION TREATMENT PROGRAM

The initial cost of enrollment of the WV DUI Safety and Treatment Program is $400 plus $20 for the required Responsible Decisions Educational Book. Enrollment and the book can be ***PAID IN THE FORM OF CASH (EXACT AMOUNT), MONEY ORDER, CREDIT CARD, OR A BANK DEBIT CARD BEFORE ATTENDING ORIENTATION.*** This must be paid to get into Orientation: A valid picture ID or Driver's License & Driver Record is required when making initial payment or no later than orientation.

The following forms must be completed by the client when payment for the DUI program is made: DUI State Report, Financial Data Sheet, and Release of Information (ROI) for the DMV and Telehealth ROI.

The DUI enrollment and Financial Data Sheet must be put into Evolv the same day the 400.00 payment is made & the Enrollment Urine drug screen needs to be done and reported to the DUI dept. There will be two random drug screens during the 6 week class that cost $35 each for a total of three unless treatment plan changes take place.

Jackson County & Roane County: Enrollment, Book, Financial, DMV ROI and Telehealth ROI will be put into Evolv by Diana Mace

Please email James, RJ Jacob, and Mary Kendle all forms the client fills out.

All counties but Jackson and Roane, Mary will add the DUI Enrollment note and DUI Book Charge note so the payment can be applied.

ORIENTATION IS AS FOLLOWS EXCEPT FOR HOLIDAYS:

Wood and Pleasants: EVERY THURSDAY FROM 9:00 TO 11:00 AM at 2501 Dudley Ave Bldg #7

Roane: TUESDAY BEGINNING AT 9:00 AM THE WEEK BEFORE CLASS STARTS Spencer office

Jackson: TUESDAY BEGINNING 9:00 AM THE WEEK BEFORE CLASS STARTS Fairplain office

Jackson County and Roane County: **Please advise clients that their Assessment will be completed the day of Orientation. Clients should plan accordingly as there will be a wait time so all assessments can be completed. Completed DUI packets, a copy of their ID or Driver Record must be obtained prior to the day of the orientation & assessment.**

Wood & Pleasants: The day of Orientation, enrollment is established and an Assessment will be done or scheduled for the following week to determine the appropriate level of care for the DUI program.

DEPENDING ON THE LEVEL OF CARE determined during the assessment, ADDITIONAL SERVICES MAY BE REQURED. MORE INFORMATION WILL BE GIVEN OUT AT THE ORIENTATION REGARDING SERVICES AND COST.

CLASSES ARE AS FOLLOWS EXCEPT FOR HOLIDAYS:

Wood and Pleasants County: THURSDAY EVENINGS FROM 6:00 TO 9:00PM FOR LEVEL I, LEVEL II IS FROM 5:00 TO 9:00 PM.

Roane County: TUESDAY MORNINGS FROM 9:00AM TO 12 NOON FOR LEVEL I, LEVEL II IS FROM 9:00AM TO 1:00PM.

JACKSON: TUESDAY EVENINGS FROM 6:00 TO 9:00PM FOR LEVEL I, LEVEL II IS FROM 5:00 TO 9:00PM

DMV-101-PS1 REV 03/18

West Virginia Department of Transportation

Division of Motor Vehicles

Request for Driving Record

Call: (304) 926-3952 Fax: (304) 957-7584

Email: DMVDrivingRecordFax@wv.gov

NOTE: **In addition to this form, please complete form DMV-101-PS2 (Driving Record Release Authorization) if you are requesting your driving record be released to anyone other than yourself. These forms must be submitted to the DMV Driving Records Section in the Kanawha City DMV Headquarters and cannot be processed in any DMV Regional Office.**

This form may be used for multiple requests and a fee of **$7.50 per name** must accompany each request. You may duplicate this form or contact the Division of Motor Vehicles for additional forms or any questions by telephoning 1-800-642-9066. Driver's license number and last name must be provided. If you do not have the driver's license number, you must provide the Social Security number and/or date of birth with an additional $1.00 fee. ***All fees are non-refundable.***

Driving Record Requesting: ○ Five Year ○ Lifetime (for CDL, State Bar or Law Enforcement Background) ● Certified (State Seal)

Driver's License Number	Name	Social Security Number	Date of Birth

Please return requested records to the following address:

Westbrook Health Services Inc. c/o DUI Director James McClain MSW LGSW — 304-485-1721 ext. 269

PLEASE PRINT COMPANY NAME, IF APPLICABLE — TELEPHONE NUMBER

2121 7th St — Parkersburg — West Virginia — 26101

MAILING ADDRESS — CITY — STATE — ZIP

Any person may request their own driving record at any DMV regional office. You must provide your state government issued ID or driver's license for proof of identification.

All other requests must be sent to the address provided below. You may not obtain information about others without their signed written consent (attach form DMV-101-PS-2) unless the request is made by a company/business on letterhead and provides a legitimate and detailed reason for the request as defined in the Uniform Motor Vehicles Records Disclosure Act (§17-A-2A-1 et seq.). ***Each request form submitted must include a copy of the requestor's valid state government issued ID or driver's license.*** *If you do not* meet these requirements, your reasons will be reviewed, and, if accepted, you will receive a driving record that excludes all personal information from the record.

Any person who knowingly or willfully obtains information under false pretenses will be in violation of state and federal law, and, if convicted, will be fined not more than $1,000 and/or imprisoned not more than one one year. I hereby certify that the information obtained from the Division of Motor Vehicles will be used for the sole purposes stated above.

(X) ______________________________

SIGNATURE OF REQUESTOR

OFFICE USE ONLY
ID VERIFIED BY: ______________________________

If you do not qualify for the information requested, you may submit a Message Forwarding Form. On this form you may write a message and the Division of Motor Vehicles will forward the form with all information you provide to the licensee at their current address in our records. This service has a non-refundable fee of $5.00. The DMV does not guarantee a delivery or response.

Any request for a driving record other than the individual's own, must be submitted to the WV-DMV at the address listed below. DMV Regional offices are prohibited from dispensing driving records to anyone requesting another individual's records.

Before mailing, be sure you've included a completed DMV-101-PS1 form, applicable fees, a copy of driver's license or photo ID, and, if applicable, a completed DMV-101-PS2 form. For employers and attorneys, a letterhead explanation must also be included.

Please mail your request to:

WV Division of Motor Vehicles
Driving Records
PO Box 17020
Charleston, WV 25317

Fax | *(304) 957-7584*
Email | *DMVDrivingRecordFax@wv.gov*
Call | *(304) 926-3952*

REQUIREMENTS FOR INDIGENT FUNDING

1) MUST BE A LEGAL WV RESIDENT AT THE TIME OF THE ARREST AND PROVIDE PROOF OF RESIDENCY FOR WV.

2) MUST BRING YOUR DRIVERS LICENSE IF IT HAS NOT BEEN REVOKED. IF REVOKED, YOU NEED TO BRING A PHOTO ID OR A RECENT PERSONAL PROPERTY TAX ASSESSMENT, OR A CURRENT VEHICLE REGISTERATION IN THE DRIVERS NAME TO VERIFY RESIDENCY FOR WV.

3) MUST BRING YOUR DRIVERS RECORD AND REVOCATION LETTER FROM THE DEPARTMENT OF MOTOR VEHICLES. YOU CAN GO ONLINE TO WWW.WVDMV.GOV TO OBTAIN THESE. THE DMV DOES CHARGE YOU FOR THIS.

4) MUST HAVE W2'S AND SIGNED INCOME TAX RETURNS FOR ALL HOUSEHOLD MEMBERS FROM THE MOST RECENT TAX YEAR.

5) IF GETTING ANY OF THE FOLLOWING: UNEMPLOYMENT BENEFITS, SOCIAL SECURITY, WORKERS COMPENSATION, CHILD SUPPORT, ALIMONY, INVESTMENT RETURNS, OR ANY OTHER FORM OF INCOME, YOU MUST BRING PROOF OF WHAT THE AMOUNTS OF THE BENEFITS ARE. IF YOU HAVE BEEN DENIED ANY OF THESE ITEMS, YOU WILL NEED TO BRING PROOF.

6) IF YOU ARE CURRENTLY NOT EMPLOYED, YOU MUST BRING PROOF FROM THE IRS TO SHOW YOU HAVE NOT FILED INCOME TAX RETURNS.

7) IF YOU ARE ON SSI DISABILITY OR MEDICARE YOU MUST BRING A LETTER FROM SOCIAL SECURITY STATING WHAT YOUR BENEFITS ARE FOR THE PREVIOUS YEAR.

8) ONCE ALL THE INFORMATION IS GATHERED, FILL OUT THE APPLICATION BUT DO NOT SIGN AND DATE UNTIL YOU BRING IT BACK TO THE OFFICE.

9) IF YOU ARE APPROVED THE STATE OF WV WILL COVER THE $400 ONE TIME ONLY. ANY ADDITIONAL CHARGES ARE YOUR RESPONSIBILITY.

10) IF YOU DO NOT MEET THE REQUIREMENT AND/OR THE STATE DOES NOT APPROVE THEN YOU WILL BE RESPONSIBLE FOR THE $400 IN ADDITION TO YOUR OTHER CHARGES

WESTBROOK
Health Services
Community Focused. People Driven.

Application - Page 1

WV DUI S & T PROGRAM
INDIGENT DETERMINATION FORM

APPLICATION DATE: _____/_____/________

DRIVER'S NAME: BIRTHDATE:

DRIVER LICENSE #: Issuing State:

DRIVER'S ADDRESS: Street:

City: State: Zip code:

TELEPHONE NUMBER: ( )

DEPENDENTS LIVING IN HOUSEHOLD (name and relationship):

Name:	DOB	Relationship

Application – Page 2

WV DUI S & T PROGRAM
INDIGENT DETERMINATION FORM - FINANCIAL STATEMENT

FAMILY INCOME** BY SOURCE

Driver Name: Date of Birth:

	DRIVER	SPOUSE	TOTAL
MONTHLY SALARY (GROSS)			
UNEMPLOYMENT BENEFITS			
SOCIAL SECURITY BENEFITS			
INVESTMENTS			
WORKERS COMPENSATION			
CHILD SUPPORT			
OTHER (ALIMONY, ETC.)			
OTHER			
TOTAL			

TOTAL FAMILY INCOME $ [ ] (from above)

TOTAL FAMILY MEMBERS [ ] (from page 1)

The above two data elements will be utilized to determine Indigent Status based on current federal poverty guidelines.

Please provide one or more of the documents described in section 4.2 (items a-d) of this procedure to verify the information reported.

****

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE THE DUI SAFETY & TREATMENT ENROLLED PROVIDER TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

SIGNATURE OF PERSON MAKING REQUEST_________________________DATE ________

Application - Page 3

ENROLLED PROVIDER DETERMINATION
Charity Care Determination

DO NOT WRITE IN THIS SECTION –
FOR DUI S&T ENROLLED PROVIDER PERSONNEL USE ONLY

This document was received and reviewed by:

Name: James McClain MSW, LGSW

Position/Title: DUI Director

Date: Click here to enter a date.

On behalf of:

Driver Name: Date of Birth:

1. Driver reports all sources of funds. Yes ☐ No ☐
2. DUI Offender meets financial eligibility of family income less than 100% of the federal poverty standard for level I basic education component full fee waiver. Yes ☐ No ☐
5. DUI Offender is a legal resident of West Virginia and has provided documentation of such. Yes ☐ No ☐

Determination:

DUI Offender is eligible for Level I indigent waiver? Yes ☐ No ☐

SIGNATURE ____DATE ________

2019 FEDERAL POVERTY GUIDELINES

Persons in Household	100% Federal Poverty Standard (Annual Limits)	100% Federal Poverty Standard (Monthly Limits)
1	$12,490	$1,041
2	$16,910	$1,409
3	$21,330	$1,778
4	$25,750	$2,146
5	$30,170	$2,514
6	$34,590	$2,883
7	$39,010	$3,251
8	$43,430	$3,619
For each additional member over 8 add...	$4,420	$368

Poverty Guidelines
Effective January 11, 2019
http://aspe.hhs.gov/POVERTY/

WESTBROOK
Health Services
Community Focused. People Driven.
2501 Dudley Avenue #7
Parkersburg, WV 26101
www.westbrookhealth.com

CLIENT NAME	DATE	TIME	CLINICIAN

WESTBROOK

Health Services

Community Focused. People Driven.

DUI Department
2501 Dudley Avenue Building #7
Parkersburg WV, 26101
Phone: 304-485-1721
Fax: 304-865-4721

NAME ON LICENSE			
PHONE NUMBER			
SOCIAL SECURITY #			
DATE OF BIRTH			
DRIVERS LICENSE #		STATE OF ISSUE	
DATE PAID			
INTERLOCK (YES OR NO)			
MILITARY (YES OR NO) CURRENT OR RETIRED?			
SPOUSE IN MILITARY (YES OR NO) CURRENT OR RETIRED?			
COUNTY OF RESIDENCE			

County	Office to Contact	Phone Number
Wood **Wirt** **Pleasants** **Ritchie** **Tyler**	2501 Dudley Ave #7 Parkersburg WV 26101	304-485-1721
Jackson	3066 Charleston Road Ripley WV 25271	304-372-6833
Roane **Calhoun**	227 Clay Road Spencer WV 25276	304-927-5200

Westbrook Health Services DUI Safety and Treatment Program

James McClain MSW, LGSW
DUI Director
304-485-1721 Ext: 269
jmcclain@westbrookhealth.com
Fax 304-865-4693

RJ Jacob, BA, MHA
DUI Instructor
304-485-1721 Ext: 120
rjacob@westbrookhealth.com
Fax 304-865-4693

Mary Kendle
Administrative Assistant DUI Program
Westbrook Health Services
304-485-1721 Ext: 118
Fax 304-865-4693

Diana Mace
DUI Roane County Support Staff
Westbrook Health Services Inc.
dmace@westbrookhealth.com
304-927-5200 Ext: 408