

**Courage Kenny  
Rehabilitation Institute  
DRIVER ASSESSMENT & TRAINING**

**Waiver Service Request Form**

**CLIENT NAME:**

**DOB:**

Phone:

2<sup>ND</sup> Phone:

Address (include apartment number)

Scheduling Contact:

Phone:

Emergency Contact:

Phone:

Guardian/Conservator of Person:

*Please send any guardianship papers*

Guardian email:

Guardian Phone:

Marital Status:  Married  Single  Widowed  Divorced  Separated

Female  Male

RACE/ETHNICITY\*:

\*Primary Language:

*\*Because we're partially funded by United Way we ask for race, ethnicity & primary language for reporting of annual statistics.*

**CASE MANAGER (CM):**

**Phone:**

**Fax:**

CM email:

County (CFR) **and** CM Agency:

**Client MA #:**

CM Agency Mailing Address:

Other Insurance:

Medicare #:

PMAP Product and Co. (SNBC, MSHO, Etc.):

Waiver Type:  BI  CADI  AC  CAC  DD  MSHO  EW  CDCS - Agency:

**PRIMARY PHYSICIAN:** (first and last name)

Primary Clinic:

Phone:

**CLIENT'S PRIMARY DIAGNOSIS:**

**Onset Date:**

All Other Diagnoses:

Special Medical Concerns:

Criminal History? (Yes or No)

**GOALS** for Services (or Comments):

**SERVICES REQUESTED**

**Driver Assessment and Training:**

Waiver Code: T-2039 UD/NPI: 1275577215

- Assessment to identify adaptive driving needs  
 Assessment to identify adaptive equipment needs for passenger only  
 Training in the use of adaptive driving equipment (must have had an assessment first)

**Forward completed referral to CKRI with client's current CSSP, IAPP, guardianship court order (if applicable) and other relevant records. Thank you.**

**Phone 612-262-7855**

**Fax 612-262-6728**

**CKRIDrivingService@Allina.com**

**CKRI will schedule services once we have received the service agreement.**