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| **Courage Kenny**  **Rehabilitation Institute** | | **Driver Assessment and Training Request Form** | | |
| **Please FAX this form to 612-262-6728. Thank you!** | | | | |
| **CLIENT NAME:** | | | **DOB:** | |
| Phone: | | | 2ND Phone: | |
| Address (include apartment number) | | | | |
| Scheduling Contact: | | | Phone: | |
| Emergency Contact: | | | Phone: | |
| Guardian/Conservator of Person: | | | *Please send any guardianship order* | |
| Guardian email: | | | Guardian Phone: | |
| Marital Status (circle): Married Single Widowed Divorced Separated | | | (Circle): 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:** | **Phone**: | | **Fax**: | |
| CASE MANAGER email: | | |  | |
| County (CFR) **and** CM Agency: | | | **Client MA #:** | |
| Other Insurance: | | | Medicare #: | |
| PMAP Product and Company (SNBC, MSHO, etc.): | | | | |
| Waiver: (Circle One) BI CADI AC CAC EW DD MSHO | | | | |
| **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:** | | | | |
| Assessment to identify adaptive driving needs (T2039-UD, CADI/CAC/BI/DD) | | | | |
| Training in the use of adaptive driving equipment (T2039-UD, CADI/BI/CAC/DD) | | | | |
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| **COURAGE KENNY REHABILITATION INSTITUTE DRIVER ASSESSMENT Phone 612-262-7855**  **245D License: 1072543-1-HCBS NPI: 1275577215 Taxonomy code: 385H00000X** | | | | |