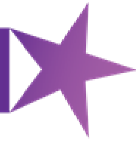

SSTAR

MID SSTAR Massachusetts Impaired Driving Program at SSTAR

REFERRAL FORM - MID / SOA / 24Q

Please check the type of referral you are requesting. (Check all that apply).

☐ Massachusetts Impaired Driving (First Offense)
☐ Evaluation for Higher Care Levels (24Q)
☐ Second Offender Aftercare (Second, Multiple Offenses)

PLEASE PRINT CLEARLY. Provide all requested information below.

Date of Arrest	B.A.C.	Date of Referral	Driver's License #	Social Security No.

Name of Referred Client / Probationer	Date of Birth	Primary Language

Complete Street or Mailing Address (Street, City/Town, State, Zip Code)

Primary Phone	Text Capable?	Email (Preferred) or Secondary Phone Number (if applicable)

Probation Officer	APO/CPO Phone	APO/CPO Fax

Referring Court	Probation File Number

First Offender ONLY

As a condition of acceptance into the **Massachusetts Impaired Driving (MID) Program at SSTAR**, by my signature below, I agree to pay the prevailing **first offender program** fee listed below. I agree to comply with the conditions of the payment option selected below and to communicate with MID program staff regarding any payment difficulties. I also understand that I should contact the agency within seven (7) business days of this referral if an agency representative has not contacted me.

☐ Plan A	☐ Plan B	☐ Plan C	☐ Waiver
$910.96 **due at intake.** (Paid in Full)	$410.96 **due at intake**, then $250 at Week 5 and Week 10.	$410.96 **due at intake**, then $50 per week for 10 weeks.	**(See "Court Waiver" details below)**

Court Waiver: Only a court-approved waiver signed by a judge will be accepted. Probationer is responsible for providing SSTAR with a copy of a valid waiver. Waiver forms should include probationer's name, date of birth, amount of fee waived and a judge's signature. **NO OTHER FORMS WILL BE ACCEPTED.**

Second Offender / 24Q Evaluations

As a condition of acceptance into the **Second Offender Aftercare (SOA) Program at SSTAR** or referral for a **24Q evaluation**, by my signature below, I agree to provide SSTAR with my personal health insurance. I agree that SSTAR will verify acceptance of my health insurance and coverage for outpatient treatment. Upon acceptance of my insurance, I agree that I will pay all applicable visit co-payments when due, in addition to satisfying any plan deductible or cost sharing requirements that may apply.

Please contact our Financial Specialist at (508) 679-5222 to have your insurance verified.

NO INSURANCE	INSURANCE NOT ACCEPTED *OR* SERVICES NOT COVERED
If you lack health insurance, your information will be screened for use of the DPH sliding fee scale and/or DPH contract for uninsured candidates.	If you have health insurance, but your insurance isn't accepted at SSTAR, or our services are not covered by your plan, you may have other self-pay (out-of-pocket) options.

TO MAKE PAYMENT BY CREDIT CARD OR DEBIT CARD CALL (508) 679-5222
A receipt can be sent to you by email or postal mail. Please request when paying.

Signature of Client / Probationer or Authorized Representative	Date Signed

PROGRAM CONTACT:

MID Program Assistant **Tel. (508) 324-3559** **mid@sstar.org**

→ Scan/Fax Completed Referral to (508) 673-3182. Do not email. ←

We **strongly recommend** a release of information and OUI police report accompany this referral.