NEW YORK STATE | Department of Motor Vehicles

GUIDELINES FOR THE COMPLETION AND DISTRIBUTION OF FORM DS-449

A. COMPLETE AND DISTRIBUTE FORM DS-449 AS FOLLOWS:

1. **For motorists required by the Department of Motor Vehicles to be assessed or treated before relicensing:**

   - If the motorist fails to appear for assessment, does not complete assessment, or does not consent to an assessment, the Provider should complete and send this form to the DMV immediately.
   - If treatment is not recommended, send this form to the DMV immediately upon completion of your assessment.
   - If treatment is recommended, send this form to the DMV immediately upon completion of treatment.

   Send a copy of form DS-449, with **ORIGINAL SIGNATURE**, to:

   New York State Department of Motor Vehicles
   Driver Improvement Bureau
   6 Empire State Plaza
   Albany, NY 12228

2. **For motorists that are required by a court to be evaluated or treated to satisfy the sentencing body please submit the DS-449 to the requesting court. In the case of a court referral the DS-449 is NOT to be sent to DMV.**

3. **A copy of this form must be given to the motorist upon request.**

The person who **ACTUALLY** conducts the assessment or treatment **MUST SIGN** form DS-449.

B. ASSESSMENT:

1. The Impaired Driver Assessment shall include the information necessary to make a determination as to a diagnosis of alcohol-related or substance use-related disorder in accordance with the most recent version of the Diagnostic and Statistical Manual (DSM) or the International Classifications of Diseases (ICD). Such a diagnosis shall also be based, in part, on: clinical interviews with the individual; a review of the documentation of the violation; a review of the individual's abstract of driving record; toxicology testing results; and interviews with collateral sources.

2. The Impaired Driver Assessment shall include clinical face-to-face, in-person interviews with the individual, and, if possible and appropriate, interviews with collateral sources. The psychosocial history of the individual shall include at a minimum, the following elements: Presenting Problem, Substance Use History, Education and Employment, Mental Health and Emotional Health, Medical/Health, Family, Social/Leisure, and Legal Involvement.

3. The Impaired Driver Assessment shall also include: findings and conclusions related to each of the elements assessed, a primary diagnosis, diagnostic summary and a dated signature of the Provider responsible for its findings.

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ALCOHOL AND DRUG ABUSE REHABILITATIVE PROGRAM SUMMARY

BE SURE TO KEEP A CLEAN, BLANK COPY OF THIS FORM IN YOUR FILES.
WHEN YOU NEED MORE FORMS, FAX A REQUEST TO (518) 474-6208.

PART 1 - COMPREHENSIVE ASSESSMENT - *If the assessment and treatment are conducted by different persons or agencies, a copy of this form must be forwarded by the IDP to the treatment provider after Part 1 is filled out.*

Last Name	First	M.I.	Date of Birth / /	Telephone Number ( )
Mailing Address (Number & Street)	City	Apt. # State	Zip Code	Client ID Number (if available)

REFERRAL and INCIDENTS INFORMATION - ***You must complete this section.*** *Check any boxes that are applicable, and* ***BE SURE TO ENTER THE NUMBER OF INCIDENTS.***

☐ **Chemical Test Refused** **NUMBER OF INCIDENTS** for driving under the influence of _____ Alcohol _____ Other Drugs

ASSESSMENT - ***You must complete this section.***

Initial Date of Assessment _____ **Outcome:** _____

Date Initial Assessment Completed _____ **Treatment Decision:**
☐ Treatment is Recommended ☐ Treatment is Not Recommended

Comments:

ASSESSOR - *To be completed and signed by the person* ***conducting*** *the assessment. Please print or type.*

Name of Provider _____ Address _____

Clinic (if applicable) _____ Address _____

E-Mail Address (optional) _____ Fax Number ( ) _____

Assessor Name _____ Telephone Number ( ) _____

Signature ▶ _____ Date _____ County _____

PART 2 - TREATMENT SUMMARY - *If the assessment and treatment are conducted by different persons or agencies, a copy of this form must be forwarded to the treatment provider after Part 1 is filled out.*

1. Treatment was related to: ☐ Driving under the influence of alcohol ☐ Driving under the influence of other drugs ☐ Other
2. Has treatment been completed? ☐ Yes ☐ No Date completed _____
3. Has motorist dropped out of treatment? ☐ Yes ☐ No Date dropped _____
4. Has motorist refused treatment? ☐ Yes ☐ No Date refused _____

Comments:

TREATMENT PROVIDER - *To be completed and signed by the person* ***conducting*** *the motorist's treatment. Please print or type.*

Name of Provider _____ Address _____

Clinic (if applicable) _____ Address _____

E-Mail Address (optional) _____ Fax Number ( ) _____

Treatment Provider Name _____ Telephone Number ( ) _____

Signature ▶ _____ Date _____ County _____