LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Traumatic Head and Spinal Cord Injury (THSCI) Trust Fund Program

Thank you for your interest in the Traumatic Head and Spinal Cord Injury (THSCI) Trust Fund Program.

The attached THSCI Application packet includes the THSCI Fact Sheet, THSCI Application for Services form and the Medical Eligibility form. Please make sure that when you return this packet, the **Medical Eligibility form is included**. This form **MUST be completed and signed by a MEDICAL DOCTOR** before mailing this packet back to us.

In order to comply with the National Voter Registration Act (NVRA), we have also attached a Voter Registration Declaration (VRD) form and a Louisiana Voter Registration Application (LA-VRA) to offer you the opportunity to register to vote. If you would like to register to vote, fill out the attached VRD and LA-VRA forms and mail them to us along with the other completed forms in this packet.

It is important that you mail us the **ORIGINAL LA-VRA** form OR you can mail it directly to the Registrar of Voters' (ROV) office in the parish in which you live. Please note that we are only allowed to forward the LA-VRA form to the ROV office if the form contains your name, address and signature. Also, the ROV office will **NOT** accept copies of the LA-VRA form.

PLEASE DO NOT FAX THE DOCUMENTS IN THIS PACKET BACK TO US.

Please **mail** the **original completed** forms to:

THSCI Trust Fund Program
P.O. Box 2031 – Bin #14
Baton Rouge, La 70821-2031

If you have any questions or need any additional information, please contact our office at 1-888-891-9441 or (225) 219-8673.

For additional resources, please contact:

The Brain Injury Association of Louisiana Resource Center
8325 Oak Street
New Orleans, La 70118
(504) 982-0685
info@biala.org

Attachments

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Traumatic Head and Spinal Cord Injury (THSCI) Trust Fund Program

What is the purpose of the THSCI Program?

The THSCI program was created to provide services in a flexible, individualized manner to Louisiana citizens who survive traumatic head or spinal cord injuries. The THSCI program assists people to return to a reasonable level of functioning and independent living in their communities.

The trust fund is designed to be a program of last resort. A person must seek assistance from all available resources before the trust fund can provide financial assistance or services.

If I qualify, what services can be paid for by this program?

- Evaluations and therapies
- Post-acute medical care rehabilitation
- Home and vehicle accessibility modifications
- Medication and medical supplies
- Personal Care Attendant Services
- Equipment necessary for activities of daily living
- Transportation for non-emergency medical appointments
- Other goods and services deemed appropriate and necessary

What limitations apply to this program?

- The THSCI Trust Fund Program must preapprove all service providers; in-state facilities/programs are given priority for approval as service providers.
- Services are provided on a first-come, first-served basis.
- All goods and services must be pre-approved before they are delivered and/or rendered.
- Expenditures shall not exceed $15,000 for any 12-month period or $50,000 in a lifetime.

Who can qualify for THSCI services?

Individuals who meet the definition for *Traumatic Head Injury* or *Spinal Cord Injury* defined as:

- *Traumatic Head Injury:* An insult to the head, affecting the brain, not of a degenerative or congenital nature, but caused by an external physical force that may produce diminished or altered state of consciousness which results in an impairment of cognitive abilities or physical functioning.
- *Spinal Cord Injury:* An insult to the spinal cord not of a degenerative or congenital nature, but caused by an external physical force resulting in paraplegia or quadriplegia.

AND

Individuals who:

- Are residents of Louisiana, officially domiciled in the state at the time of injury and during the provision of services;
- Have a reasonable expectation to achieve improvement in functional outcome with assistance (per the treating physician);
- Have exhausted all other Medicare and Medicaid sources (as attested to by the applicant);
- Provide proof of denial from other sources (if requested);
- Are willing to accept services from an approved facility/program;
- Complete and submit appropriate application for services;
- Are willing to participate in the development of an Individualized Service Plan that outlines the services that will be provided by the Trust Fund

For more information about the THSCI program or to apply for services, please call 1-888-891-9441. The call is free.

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

APPLICATION FOR SERVICES

TRAUMATIC HEAD AND SPINAL CORD INJURY TRUST FUND PROGRAM

P.O. Box 2031-BIN #14, BATON ROUGE, LA 70821-2031 • PHONE 1-888-891-9441 OR (225) 219-2410

Applicant's Name (Last, First, MI):		Social Security #	Date of Birth: (mm/dd/yyyy)
Home Address:			Apartment or Suite Number
City:	State:	ZIP Code:	Parish:
Mailing address (if different from home address):			Apartment or Suite Number
City:	State:	ZIP Code:	Parish:
Phone Number:	Alternate Contact Name:		Alternate Contact Phone Number:
Email Address:		Sex: ☐ Male ☐ Female	Highest Grade Completed:

Other Health Insurance (if know): ☐ Medicaid ☐ Medicare ☐ Other Insurance ☐ N/A If other, list here _____	Waiver Programs (if know): ☐ NOW Waiver ☐ Supports Waiver ☐ LTPCS ☐ ADHC Waiver ☐ CCW Waiver ☐ SPAS ☐ N/A If other, list here _____

Have you ever been enrolled in the Traumatic Head and Spinal Cord Injury Trust Fund Program? ☐ Yes ☐ No

Primary Diagnosis: ☐ Traumatic Brain Injury ☐ Spinal Cord Injury ☐ Both

Primary Treating Physician's Name:		Phone Number:
Mailing Address:	State:	ZIP Code:
How were you injured?		Date of Injury: Age at time of Injury:
Where were you living AT TIME of the injury?	City:	State:
Is this where the ACCIDENT TOOK PLACE? ☐ Yes ☐ No	If No, City:	State:

How did you hear about the THSCI program? _____	How did you obtain this application? ☐ Brain Injury Assoc. ☐ Website ☐ Other _____

PLEASE READ CAREFULLY – CALL THE NUMBER AT THE TOP OF THE APPLICATION IF YOU HAVE ANY QUESTIONS.

I hereby apply for services through the Louisiana Traumatic Head and Spinal Cord Injury (THSCI) Trust Fund Program. I will voluntarily provide information relative to my disability/injury/accident and resources available to me. Refusal to provide such information could affect my eligibility for services. I understand that such information will be held confidential and will be used only insofar as it affects my eligibility for the program and the delivery of services. Information will be released only with my written consent or as otherwise authorized by the policy of the Louisiana Traumatic Head and Spinal Cord Injury Trust Fund Program.

I understand that eligibility decisions will be made without regard to sex, race, creed, color or national origin. I further understand that eligibility decisions will be made without regard to disability unless, and only to the extent necessary, authorized by law to comply with Act 654 of the 1993 Louisiana Legislature created for the THSCI program. I further understand that I must be willing to accept services from an approved facility or program and cooperate with my Case Manager and the THSCI program staff regarding services, plans, appointments, etc.

I agree to notify my Case Manager and the THSCI program office within 30 days if I have a change to my physical or mailing address or my phone number.

I certify that I am a current resident of the state of Louisiana and officially domiciled in the state of Louisiana at the time of the injury. In the event I move to another state, I understand that I will no longer be eligible for the THSCI program.

I understand that if my address or phone number changes and I fail to notify the THSCI program office, every reasonable attempt will be made to contact me. If the THSCI program office is unable to contact me, my name will be removed from the waitlist and I must reapply for services.

I certify that the information I have given is true, correct and complete to the best of my knowledge and that knowingly providing false or incorrect information is cause for immediate termination of benefits and that I may be required to reimburse, in whole or in part, the Louisiana Traumatic Head and Spinal Cord Injury Trust Fund for funds provided to pay for the cost of services I have received.

DO NOT SIGN UNLESS YOU FULLY UNDERSTAND THE ABOVE STATEMENTS

_____ _____

Signature of Applicant Date of Application

_____

Signature of Representative or Guardian (required if applicant is under 18 yrs of age)

PLEASE ASSURE THE MEDICAL ELIGIBILITY FORM IS ATTACHED TO THIS APPLICATION OR IT WILL NOT BE PROCESSED.

PLEASE MAIL THE ORIGINAL APPLICATION TO:

THSCI Trust Fund Program
P O Box 2031 Bin #14
Baton Rouge, La 70821-2031

THSCI OFFICE USE ONLY: Application Complete ☐ Yes ☐ No MEF Complete/Attached ☐ Yes ☐ No

THSCI Staff Signature: _____ Date Reviewed: _____

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

☐ New Applicant ☐ Current Participant

Patient's Name: _____

Date of Birth: _____

Traumatic Head & Spinal Cord Injury Trust Fund (THSCI)

MEDICAL ELIGIBILITY FORM

(MUST be completed by Treating Physician)

MEDICAL DOCUMENTATION INSTRUCTIONS AND REQUIREMENTS

The Traumatic Head and Spinal Cord Injury (THSCI) Trust Fund program through the State of Louisiana has either received an application from one of your patients or the patient is currently eligible for the program and we need to determine if the patient shall continue to be eligible for the program. The program needs medical information/documentation from you that will be evaluated, along with other non-medical information, in connection with his or her application or existing eligibility. This documentation will be used in determining his or her eligibility for the THSCI Trust Fund program.

Please complete the enclosed Medical Eligibility Form and return to the address below within 10 business days of receipt of this correspondence. If this Medical Eligibility Form request is in connection with a new application, please return this form to the participant so that he or she may attach this form to the application before submitting it to the program for review. If this form request is NOT in connection with a new application, you may also fax the Medical Eligibility form to **(877) 747-0983.** Please note that the State of Louisiana's THSCI Trust Fund program cannot pay for the request for any medical documentation or information received from a physician.

LDH/OAAS/THSCI Trust Fund Program
ATTN: Tonia Gedward 2nd Floor
P. O. Box 2031, Bin #14
Baton Rouge, La 70821-2031

If the individual is deemed eligible for the THSCI Trust Fund program, the program would provide funding for flexible services and support for those with traumatic head and traumatic spinal cord injuries. The program enables individuals to return to a reasonable level of functioning and independent living in their communities. Services provided to eligible participants may include: case management, inpatient and outpatient rehabilitation, home and vehicle modifications, and assistive technology.

If you need assistance or have any questions, please call (225) 342-8673 or (888) 891-9441.

☐ New Applicant ☐ Current Participant

Patient's Name: _____

Date of Birth: _____

Traumatic Head & Spinal Cord Injury Trust Fund (THSCI)

MEDICAL ELIGIBILITY FORM

(MUST be completed by Treating Physician)

I. STATE OF INJURY- *Please indicate the participant's injury and current state as of today. (Check all that apply)*

☐ **SPINAL CORD INJURY (SCI) [The patient currently meets the definition of SCI.]**

☐ The injury is a result of an insult to the spinal cord caused by external force.

Cause of Injury: _____

Result of Injury: ☐ Paraplegia ☐ Quadriplegia ☐ N/A

☐ The injury is a result of a degenerative or congenital nature (Not an external force).

☐ The injury is NOT a result of an insult to the spinal cord caused by an external force.

☐ **TRAUMATIC HEAD INJURY (THI) [The patient currently meets the definition of THI].**

☐ The injury is a result of an insult to the head, affecting the brain, caused by an external force.

Cause of Injury: _____

Result of Injury: ☐ Mild TBI (Glasgow Coma Scale score 13-15) ☐ Moderate TBI (Glasgow Coma Scale core 9-12) ☐ Severe TBI (Glasgow Coma Scale core 8 or less) ☐ N/A

Impairments: ☐ Cognitive Functioning ☐ Physical Functioning ☐ N/A

☐ The injury is a result of Anoxia.

Cause of Injury: ☐ Stroke or Cardiac Arrest

☐ External Force (Drowning, Poisoning, electrocution, etc)

☐ Other _____

☐ The injury is a result of a degenerative or congenital nature (Not an external force).

☐ The injury is NOT a result of an insult to the head, affecting the brain, caused by an external force.

☐ **NO TRAUMATIC SPINAL CORD OR HEAD INJURY**

II. FUNCTIONAL OUTCOMES

☐ YES ☐ NO **Does this patient have a reasonable expectation to achieve improvement in functional outcomes with assistance?** *Specifically, can the patient benefit from provision of appropriate services and supports through the THSCI Trust Fund program, which can assist the patient in returning to a reasonable level of functioning and independence in his/her community.*

☐ New Applicant ☐ Current Participant

Patient's Name: _____

Date of Birth: _____

III. MEDICAL HISTORY AND PROGNOSIS

Please list any other medical information related to the patient's injury that you feel is relevant to the medical determination and may assist the program in making an informed eligibility decision (if applicable).

_____

_____

_____

_____

IV. PHYSICIAN'S INFORMATION AND ATTESTATION

I attest that the individual's condition meets the entry level definition of THI/SCI: A non-degenerative, non-congenital insult to the brain and/or spinal cord, caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment.

_____ _____

Physician's Signature Date

_____ _____

Physician's Name (Printed) Phone Number

_____

_____

Address of Physician Office

******This form is invalid without signature and legible contact information from the completing Physician******

PLEASE RETURN THIS FORM TO:

THE PATIENT (MUST BE SUBMITTED <u>WITH</u> THE PATIENT'S INITIAL THSCI APPLICATION)