BRAIN INJURY ASSOCIATION OF NEW HAMPSHIRE

52 Pleasant Street | Concord, NH 03301
Help line: (800) 773-8400
Tel: (603) 225-8400
Fax: (603) 228-6749
www.bianh.org

THE VOICE OF BRAIN INJURY

Brain Injury Community Support Program

A Collaborative Program of the Bureau of Developmental Services and the Brain Injury Association of New Hampshire

Dear Applicant,

Thank you for your interest in the Brain Injury Community Support Program. This program is collaboration between the Bureau of Developmental Services and the Brain Injury Association of New Hampshire (BIANH) and was designed to financially assist individuals with brain injuries to live in the community. Please mail your completed application to:

Brain Injury Community Support Program
Brain Injury Association of NH
52 Pleasant Street
Concord NH 03301

- Applications need to have both a signed release and medical documentation of the brain injury.
- Include a cover letter describing daily life with a brain injury and how the funds will assist you.
- Please make sure that contact information is available to clarify application if needed.
- **Please understand that all required information must be completed before consideration for funding can be reviewed by the Committee.**
- **Applications must be completed and received by the office, by 2:00 pm the last Wednesday of the month in order to be reviewed**. The Committee meets the following Wednesday to review completed applications. It is the applicant's responsibility to give the Medical Disability Form to their Primary Care Physician or Neurologist; the applicant is responsible to follow-up with their Physician to be sure that the form has been completed and forwarded to BIANH.
- Please utilize the enclosed checklist to double check that all required information is completed.
- **Incomplete applications will delay review of request by the Committee.**
- Please provide us with a copy of statements for bills for which you are requesting grant funds. Any equipment, supplies, home modifications, or similar must be deemed medically necessary by your Physician and a note from your doctor must be submitted.
- A written statement or invoices from two (2) different vendors is needed for the requested item.
- **Please note that approved grants are paid directly to the vendor and not to the applicant.**

If you have any questions, please 603-225-8400.

BICSP Grant Committee

Enclosures:

Description of Eligibility	Application
Financial Information Form	Medical Disability Form
Release of Information	Checklist

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Description of Eligibility

Purpose: To support individuals with brain injuries or neurodegenerative disorders, to live in the community.

Eligibility:

- Neurodegenerative Disorder; i.e. Huntington's, Multiple Sclerosis, Stroke, Tumor
- Traumatic Brain Injury with cognitive decline as a result of the injury and impairment to one's ability to function in everyday life
- Occurs between the ages of 22 and 60
- Financial hardship and does not have other assets that could be accessed

(Eligible for Area Agency Services differ from this Program's eligibility)

Funded Services and Limits:
$2,000.00/year from date of application / Lifetime cap: None

- Short term financial crisis
- Transition back into and/or support to maintain community relationships
- Safe and dignified living

Below is a list of services that would be available:

- Home modifications Respite Assisted technology
- Specialized equipment Medical/dental Evaluations
- Specialized treatment (if not covered by Medicaid or insurance)
- Transportation (Purchase of vehicles excluded)
- Financial crisis (fuel oil, rent, etc.)
- Other requests are reviewed on an individual basis

Services That **Will Not** Be Funded:

- Anticipated expenses (only expenses that are due or past due will be considered)
- Education and Employment expenses (Assistance is provided by Vocational Rehabilitation)
- Reimbursement (the grant will not reimburse individuals for expenses that have already been paid)

Process:

- **All completed applications (including brief letter outlining your request, completed medical form, all copy of vendor request items, etc.) are to be sent to:**
  The Brain Injury Association of NH Attn: BICSP Program and must be received by 2:00 pm the last Wednesday of the month in order to be reviewed for the next meeting. Any application received after this time will be held until the following month for review.
- Applicants will be notified if his/her application is not complete
- Completed applications will be reviewed by the Committee on the first Wednesday of the month
- Applicants will be notified by mail of the Committee's decision

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Brain Injury Community Support Program Application

Date: _____

Name: _____

Mailing Address: _____

_____

Email Address: _____

Phone number: _____

Date of Birth: _____

Referred by (Name/Organization): _____

Diagnosis: ___ Traumatic Brain Injury ___ Huntington's Disease

___ Stroke ___ Multiple Sclerosis

___ Brain Tumor Other _____

Have you applied for any HC/BC Waiver? ___ Choices for Independence

___ ABD ___ DD

When did you receive your injury/ diagnosis? _____

If you have a brain injury, how did you receive your injury?

_____

_____

_____

_____

Describe why you are requesting funding:

_____

_____

_____

_____

Total amount needed: $ _____

Amount individual/family can contribute: $ _____

Other resources: $ _____

Balance needed: $ _____

From what other organizations have you requested funding? Amount Received/Pending

1._____

2._____

3._____

4._____

5._____

Please see the sheet entitled Checklist for Application Completion. **If all required information is not received, there will be a delay in processing your application** until all the required information is received.

Brain Injury Community Support Program
Brain Injury Association of New Hampshire
52 Pleasant Street
Concord, NH 03301

Financial Information*:* **Income**

What is your present MONTHLY income **after taxes**

Employment	$
Unemployment	$
Worker's Comp	$
Rental Income	$
Trust or interest income	$
Retirement income	$
Child Support	$
SSDI and/or SSI	$
APTD	$
TANF	$
General Assistance or Town Welfare	$
Food Stamps	$
Fuel Assistance	$
VA Disability	$
HUD Housing/Rental Assistance	$
Other (please specify)	$
Other (please specify)	$
Total Monthly Income	$

Who else contributes to the household **income**?

Name	**Source of Income**	**Monthly Amount**
		$
		$
		$
Total Monthly Household Income		$

Assets: Please describe your own and your household's savings and assets

Asset	**Financial Institutions**	**Your Total Amount/Value**	**Household Amount/Value**
Savings			
Savings			
Checking			
Checking			
CD/Stocks			
IRA			
Other			
Total Household Assets			

Financial Information: **Expenses**

Please list your own and household MONTHLY living expenses

Monthly Expense	**Household**
Rent/Mortgage	$
Rental/Homeowners Insurance	$
Heat	$
Electricity	$
Water/Sewer	$
Property Tax	$
Phone	$
Cell Phone	$
Cable	$
Food	$
Clothing	$
Other household expenses	$
Vehicle Payment #1	$
Vehicle Payment #2	$
Vehicle Insurance	$
Vehicle gas, maintenance, etc.	$
Health Insurance	$
Monthly medical expenses (including co-pays)	$
Dental expenses	$
Credit Cards	$
School Loans	$
Other Loans	$
Misc. movies/pets/laundry/tobacco	$
Other	$
Other	$
Total Monthly Expenses	$

Who else contributes to the household **expenses**?

Name	**Source of Income**	**Monthly Amount**
		$
		$
		$
Total Monthly Household Expenses		$

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Medical Disability Report

To: _____
(Name of medical/healthcare provider)

Individual's Name: _____

Date of Birth: _____

SS#: _____

Individual/Guardian Signature: _____

Date: _____

****Applicant is responsible for obtaining this information for medical review**
The above individual is requesting financial support from the Brain Injury Community Support Program. The application process requires the following questions to be answered by his/her doctor or neurologist. Please complete the following questions and return it to:

Brain Injury Community Support Program
Brain Injury Association of NH
52 Pleasant Street
Concord, NH 03301
603-228-6749 (fax)

If you have any questions, please call BIANH at 603-225-8400.

Thank you in advance for your assistance.

Individual's Name: _____

Doctor's Name: _____

Please answer the following questions as they relate to the individual's brain injury:

1. Diagnosis of individual:

2. Cause of disability:

3. Current daily living/functioning:

4. Changes in functioning due to disability/brain injury:

Signature of Doctor: _____

Date: _____

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PROFESSIONAL AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize the Brain Injury Association of NH
(Individual's Name/Guardian)
to review and obtain copies of all medical, hospital or other pertinent records or information in order to assist in providing services and in developing a service plan for

_____
(Individual's Name SS# DOB)

I authorize the Brain Injury Association of NH to share information received with any institution that through a private or public funded program is a consideration for or is actually paying for all or part of my program.

I also give permission to discuss any medical, hospital or other pertinent records or information with any contact you provide to us to assist in seeking services and payments for such services.

I have had this form read and explained to me and understand its contents. I agree that a photocopy of this authorization be accepted with the same authority as the original.

I permit the use of facsimile or other electronic devices in transferring my records as needed. Sender assures all due care to protect confidentiality of records in using electronic devices.

This consent shall expire on _____

Signed _____ Date _____
Self/Guardian

Guardian's Phone Number _____

Individual's Address _____

_____

Individual's Phone Number _____

Witness _____

Relationship _____

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Checklist for Completion of Application

___ I have answered ALL questions on the application.

___ I have listed all other Resources that I have tried to receive assistance from and the outcome of these contacts.

___ I have signed the Release of Information and have included an address and telephone number .

___ I have provided a copy of medical information documenting a brain injury, Huntington's Disease, or Multiple Sclerosis completed and signed by physician. **It is the applicant's responsibility to obtain the completion of the Medical Disability Form from his/her physician. Your doctor can fax or mail the completed form to the address or number stated in the cover letter.**

___ I have provided written documentation of medical necessity from my Physician for any equipment, supplies, home modifications, or similar item(s).

___ I have included 2 invoices/quotes for items funding is requested for, as outlined in the cover letter.

___ I have included a cover letter/personal statement describing daily life with a brain injury and how the funds will assist you. (Letters from advocates/mentors are also accepted)

On the Financial Information Form:

___ I have completed all monthly income.

___ I have completed the income of anyone else who lives with me.

___ I have included all savings and other assets I have.

___ I have included all savings and assets of those who live with me.

___ I have completed every line of my monthly expenses.

___ I have listed the expenses of those who live with me.