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

Dear Applicant,

Thank you for your interest in The Brain Injury Association of NH's Neuro-Resource Facilitation Program. This program aims to assist families and individuals who have experienced a brain injury or stroke.

The Neuro-Resource Facilitation Program has come about from the passing of Senate Bill 182. This bill appropriates funding to provide a statewide program to assist families and survivors with identifying and accessing resources in their community.

If you are struggling with attaining the appropriate services, we ask that you fill out the enclosed application and release form and return it in the envelope provided. The Neuro-Resource Facilitation Coordinator will contact you to further discuss how this program works.

To be eligible for the program you need be a legal resident of New Hampshire, have experienced a brain injury or stroke before the age of 60, be expected to benefit from the services, have a personal champion(1) or guardian, and have goals or objectives you would like our assistance with.

If you have any questions regarding the Brain Injury Association of New Hampshire's Neuro-Resource Facilitation Program, please feel free to call 603-225-8400 or 800-773-8400.

Sincerely,

Brain Injury Association of New Hampshire

Enc. Program Resource Sheet
Application (Intake Form)
Release of Information

(1) Champion: Def. Natural support person that the Brain Injury Association of NH is allowed to speak with on your behalf; cannot be a professional or hired assistance. Examples include spouse, friend, brother/sister, co-worker, etc.

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Neuro-Resource Facilitation Program
Resource Sheet

Neuro-Resource Facilitation: Def. A partnership that assists individuals to receive information that will enable them to make informed choices for services and supports in meeting their individual needs.

This involves individuals living with brain injury or stroke and their personal support systems working in partnership with Neuro-Resource Facilitators who provide assistance in navigating systems and acquiring services and support to achieve agreed upon goals. We do not directly provide the services, but the support and resources in acquiring them.

Eligibility:

- Legal Resident of NH.
- Have experienced a Brain Injury or Stroke before the age of 60.
- Be expected to benefit from the services.
- Have a personal champion or guardian.
- Have goals or objectives that they would like us to assist them with.

Neuro-Resource Facilitation Activities may include:

- Completing an intake form including identifying information, participant's needs and current resources.
- Educating the community and personal support system(s) to understand how barriers may impact the lives of the participants.
- Planning mutually agreed upon goals with services and/or supports needed to reach them.
- Identifying and locating resources, services and supports.
- Facilitate access through the development and/or referral of resources, services and supports.
- Monitoring the status of the goals and the quality and appropriateness of services and supports. Adjusting services and supports as needed to attain goals.
- Provide outreach services to help identify individuals who could benefit from this program.
- Assisting participants to advocate for themselves.

The Neuro-Resource Facilitation Program does not provide any direct services.

If you have a referral or questions about the Brain Injury Association's Neuro-Resource Facilitation Program, please call (603) 255-8400 or (800) 773-8400.

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NEURO-RESOURCE FACILITATION INTAKE FORM

Name: _____ E-Mail Address: _____
Address: _____ Date of Birth: _____
_____ S.S.#: _____
Phone Number: _____ Application Completion Date: _____

How did you receive your injury? _____
Date of your injury: _____
How old were you at the time of your injury? _____

REQUIRED
Guardian or Champion Name: _____
Phone #: _____
Relationship: Champion or Guardian (please provide documentation)

Are you receiving Area Agency Services? Y N
Have you ever served in the Military or National Guard? Y N

Doctors/Facilities Attended:

NAME	ADDRESS	PHONE#

Benefits you are receiving:

SSI	Y	N	Medicaid	Y	N	(If Yes, Medicaid #_____)
SSDI	Y	N	Medicare	Y	N	
APTD	Y	N	Private Ins.	Y	N	

I need assistance with (circle all that apply):

Benefits
Housing
Advocacy
Financial Assistance
Transportation
Counseling
Doctors
Legal
Employment
Respite
Day Services
Therapy
Other: _____

How did you hear about this program (please circle one)?

- Called the office
- Training/workshop
- Flyer
- Social Worker/Case Manager
- Someone else

Is someone filling out this form on your behalf? Y N
If yes, who? _____

We understand that a referral has been sent to the Brain Injury Association of NH for the Neuro-Resource Facilitation Program. We understand that signing this form does not mean that we need to participate in the program.

Individual/Guardian Signature: _____

Champion or Ward Signature: _____

Is there anything you would like us to know?

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NEURO-RESOURCE FACILITATION

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 or Guardian – please circle one

Guardian/Individual Phone # _____

Individual's Address _____

_____

Signed _____ Date _____

Champion or Ward –please circle one

Champion / Ward Phone # _____