Transition Program

The Brain Injury Association of New Hampshire is a private, non-profit, survivor, and family run organization representing over 15,000 NH residents who are experiencing an acquired brain injury or stroke. The Association was founded in 1983 by NH parents seeking to bring their children home from out of state facilities.

In 2009, The Brain Injury Association of New Hampshire added a Transition Program to their list of offered supports. The Transition Program specializes, but is not limited to helping those with a diagnosis of brain injury, MS, Huntington’s, or Stroke. Assistance to any individual with health issues to transition from any facility back into their community is available. The Transition Coordinator works with individuals to carry out their discharge plan. Participants work in collaboration with the Transition Coordinator and their team to ensure a successful transition. Post transition follow-up calls and/or visits are provided.

Who is Eligible?
Anyone whom is: a New Hampshire resident; living with a health issue, and/or individuals participating in the Community Passport or Choices for Independence Programs of the Bureau of Elderly and Adult Services of NH.

What Community Services will be Explored?
Services may include, but are not limited to, exploring funding and resources for home modifications, personal care services, homemaker services, transportation coordination, housing needs, healthcare needs, and other supports as identified for the individual.

How can a Referral be made?
Referrals to the Transition Program can be made by individuals, family members, facility staff, advocates, or medical staff. Referrals can be made by calling or visiting www.Bianh.org, 603-225-8400 or 1-800-773-8400 (NH only)
Transition Program Application

Name: ______________________________  E-Mail Address: __________________________
Address: ____________________________  Date of Birth: _____________________________
____________________________________  S.S. #: ______________________________
Phone Number: __________________________

How did you receive your injury? ____________________________
Date of your injury: ______________________
How old were you at the time of your injury? ____________

Guardian/Contact Name: ____________________________
Phone #: ____________________________  Best Time to Call: _______________________
Relationship: __________________________

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

Doctors/Facilities Attended:

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<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>PHONE #</th>
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Benefits you are receiving:

SSDI  Y  N
SSI  Y  N
APTD  Y  N

Medicaid  Y  N
Medicare  Y  N
Private Ins.  Y  N

MCO: __________________________

I need assistance with (circle all that applies):

Benefits  Other __________________________
Housing
Advocacy
Financial Assistance
Transportation
Legal
Employment
Respite
Day Services
Therapy
Counseling
Doctors
How did you hear about the Transition 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?  ________________

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

Individuals/Guardians Signature  ________________________________

Is there anything you would like us to know?
Brain Injury Association of NH Transition Program

AUTHORIZATION FOR RELEASE OF INFORMATION

I ________________________________ authorize ________________________________
(Individual’s Name) to review and obtain copies of all medical, hospital or other pertinent records or information in order to assist in providing services for:

__________________________________________  SS#  DOB
(Individual’s Name)  ________________________

I authorize ________________________________ to share information received with any institution/organization that is thought necessary or beneficial to my health and well being.

I also give permission to discuss any medical, hospital or other pertinent records or information with any contact to assist in obtaining 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 __________________________