

Dir: (800) 773-8400 Tel: (603) 225-8400 Fax: (603) 228-6749 E-mail: mail@bianh.org

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:				
Address:				
	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 Nationa			N	
Doctors/Facilities Attended:				
NAME ADDRESS	<u>P</u>	HONE	<u>#</u>	
Benefits you are receiving:				
SSDI Y N	Medicaid	Y	N	
SSI Y N	Medicare	Y	N	
APTD Y N	Private Ins.	Y	N	
MCO:				
I need assistance with (circle all that applies):				
Benefits	Other			
Housing	<u></u>			
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?



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Brain Injury Association of NH Transition Program

<u>AUTHORIZATION</u> <u>FOR RELEASE OF INFORMATION</u>

Ι	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:			
(Individual's Name I authorize institution/organization that is thought	SS# DOB) to share information received with any necessary or beneficial to my health and well being.		
	medical, hospital or other pertinent records or information services and payments for such services.		
	ed to me and understand its contents. I agree that a septed with the same authority as the original.		
	electronic devices in transferring my records as needed. confidentiality of records in using electronic devices.		
This consent shall expire on			
Signed Self/Guardian	Date		
Guardian's Phone Number			
Individual's Address			
Individual's Phone Number			
Witness			
Relationship			