

# 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.

The purpose of the program is to assist individuals with brain injuries live in the community. The enclosed application will need to be completed and returned to:

Brain Injury Community Support Program  
C/o Maureen Long, RN, BSN  
Brain Injury Association of NH  
PO Box 1041  
Amherst NH 03031

- Applications need to have both a signed release and medical documentation of the brain injury.
- Also include a cover letter describing the situation 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 complete including the Medical Disability Form by the last Wednesday of the month in order to be reviewed by the Committee at the scheduled meeting the first Wednesday of the month. It is the applicant's responsibility to follow-up with his/her physician to be sure that the form has been completed and forwarded to Maureen Long.
- 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 may be requesting grant consideration. Any equipment, supplies, home modifications, must be deemed medically necessary by your physician and must be submitted by your doctor in writing; and, you must submit two (2) written statements from two (2) different vendors. Please note that approved grants are paid directly to the vendor and not to the applicant.

If you have any questions, please call me at 603-769-0203.

Sincerely,

Maureen Long, RN, BSN

Enc. Description of Eligibility  
Application  
Financial Information Form  
Medical Disability Report  
Release of Information  
Checklist

C/o Brain Injury Association of New Hampshire PO Box 1041 Amherst NH 03031  
603-769-0203 (Phone) 603-228-6749 (Fax)

# Brain Injury Community Support Program

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## Description of Eligibility

Purpose: To support individuals with brain injuries to live in the community.

### Eligibility:

1. Meet He-M 522 eligibility. An acquired brain disorder means a disruption in brain function:
  - a. Is not congenital or caused by a birth trauma;
  - b. Presents a severe and life-long disabling condition which significantly impairs a person's ability to function in society; and
  - c. Occurs prior to age 60 and after 21<sup>st</sup> birthday.

(Please note that being found eligible for this program does not automatically make you eligible for Area Agency Services.)

2. Not eligible for the Community Waiver except for extreme circumstances as determined by the committee.
3. Financial hardship
4. Do not have other assets that could be accessed
5. Modest level of income

### Funded Services:

There are three broad areas covered under this program:

1. Short term financial crisis
2. Transition back into and/or support to maintain community relationships
3. Safe and dignified living

Given these broad categories, below is a list of services that would be available:

1. Home modifications
2. Respite
3. Assisted technology
4. Specialized equipment
5. Specialized treatment (if not covered by Medicaid or insurance)
6. Transportation (Purchase of vehicles excluded)
7. Financial crisis (fuel oil, rent, etc.)
8. Medical/dental
9. Evaluations
10. Other

### Limits:

\$2,000.00/year from date of application or considered exceptions from the committee

Lifetime cap: None

### Process:

1. All referrals are to be sent to the Brain Injury Association of NH %Maureen Long
2. Applicants will be notified if his/her application is not complete
3. Completed applications will be reviewed by the Committee on the first Wednesday of the month
4. 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: \_\_\_\_\_

\_\_\_\_\_

Phone number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Referred by (Name/Organization): \_\_\_\_\_

Diagnosis:  Traumatic Brain Injury

Stroke

Multiple Sclerosis

Huntington's Disease

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?

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Describe why you are requesting funding:

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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.

Brian Injury Community Support Program  
C/o Brain Injury Association of New Hampshire  
Attn: Maureen Long  
PO Box 1041  
Amherst NH 03031

## 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)	\$
<b>Total Monthly Income</b>	\$

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

Name	Source of Income	Monthly Amount
		\$
		\$
		\$
<b>Total Monthly Household Income</b>		\$

**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			
<b>Total Household Assets</b>			

## Financial Information: **Expenses**

Please list your own and household living expenses

<b>Monthly Expense</b>	<b>Household</b>
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	\$
<b>Total Monthly Expenses</b>	\$

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

<b>Name</b>	<b>Source of Income</b>	<b>Monthly Amount</b>
		\$
		\$
		\$
<b>Total Monthly Household Expenses</b>		\$

# Brain Injury Community Support Program

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## Medical Disability Report

To: \_\_\_\_\_  
(Name of medical/healthcare provider)

Individuals Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_

Individual/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

The above individual is requesting support from the Brain Injury Community Support Program. The application process requires the following questions to be answered by his/her doctor. Please complete the following and return it to:

Brain Injury Community Support Program  
Brain Injury Assoc. of NH  
Attn: Maureen Long, RN, BSN  
PO Box 1041  
Amherst, NH 03031  
603-228-6749 (fax)

If you have any questions, please call Maureen Long at 603-769-0203.  
Thank you in advance for your assistance.

Individual's Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Please complete the following questions:

Diagnosis of individual:

Cause of disability:

Current functioning:

Changes in functioning due to disability:

Signature of Doctor: \_\_\_\_\_

Date: \_\_\_\_\_



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## Checklist for Completion of Application

- \_\_\_ I have answered all the questions on the application form on the front and back.
- \_\_\_ I have included listing 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 your 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 Maureen Long at the address or number stated in the cover letter.**
- \_\_\_ **I have included all necessary statements or proposals from vendors as outlined in the cover letter.**

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.