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 to live in the community. The enclosed application will need to be completed and returned to:

Brain Injury Community Support Program
Attn: Faye Lesniewski
Brain Injury Association of NH
109 North State Street, Suite 2
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 complete including the Medical Disability Form, by the **last Wednesday of the month** in order to be reviewed. The Committee meets the first Wednesday of the month. It is the applicant's responsibility to give the Medical Disability Form to your Physician and to follow-up with your Physician to be sure that the form has been completed and forwarded to Faye Lesniewski.
- 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, must been deemed medically necessary by your Physician and must be submitted by your doctor in writing. Also, 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 603-225-8400.

Sincerely,

Faye Lesniewski, BA
Programs and Services Assistant
Enc. Description of Eligibility
Application
Financial Information Form
Medical Disability Report
Release of Information
Checklist

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Description of Eligibility

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

Eligibility:

- Neurodegenerative Disorder; i.e. Huntington's, Multiple Sclerosis, Stroke, Tumor,
- Traumatic Brain Injury
- Presents as a severe and life-long disabling condition which impairs a person's ability to function in everyday life
- Occurs at any age
- Financial hardship
- Do not have other assets that could be accessed

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

Funded Services:

There are three broad areas covered under this program:

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

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

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

Limits:

$2,000.00/year from date of application or considered exceptions from the committee
Lifetime cap: None

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: Faye Lesniewski and must be received **by 3 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 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: _____

_____

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?

_____

_____

_____

_____

_____

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.

Brian Injury Community Support Program
Brain Injury Association of New Hampshire
Attn: Faye Lesniewski
109 North State Street, Suite 2
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 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)

Individuals Name: _____

Date of Birth: _____

SS#: _____

Individual/Guardian Signature: _____

Date: _____

****Applicant is responsible for obtaining this information for medical review**
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 Association of NH
Attn: Faye Lesniewski
109 North State Street, Suite 2
Concord, NH 03301
603-228-6749 (fax)

If you have any questions, please call Faye Lesniewski at 603-225-8400.
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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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 _____

C/o Brain Injury Association of New Hampshire, 109 North State Street, Suite 2, Concord, NH 03301
603-225-8400 (Phone) – 603-228-6749 (Fax)

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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.

C/o Brain Injury Association of New Hampshire, 109 North State Street, Suite 2, Concord, NH 03301
603-225-8400 (Phone) – 603-228-6749 (Fax)