



109 North State Street | Suite 2 | 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

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 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 603-340-2609 or 800-773-8400.

Sincerely,

Maureen Long, RN, BSN, CBIS  
Case Manager

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

## **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 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 1(800) 773-8400.**



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NEURO-RESOURCE FACILITATION INTAKE FORM

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:

Table with 3 columns: NAME, ADDRESS, PHONE#

Benefits you are receiving:

Table with 6 columns: SSDI, SSI, APTD, Medicaid, Medicare, Private Ins. and their respective Y/N status.

I need assistance with (circle all that apply):

- List of assistance categories: 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? \_\_\_\_\_

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

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

Is there anything you would like us to know?



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/Guardian

Guardian's Phone Number \_\_\_\_\_

Individual's Address \_\_\_\_\_

\_\_\_\_\_  
Individual's Phone Number \_\_\_\_\_

Witness \_\_\_\_\_

Relationship \_\_\_\_\_