3904 Franklin Road, Suite B
Roanoke, Virginia 24014-3039
Toll Free: 1-866-720-1008
Fax: 540-344-9755
info@bisswva.org

Application for Services

Information About the Person Needing Services

Name: ______ Primary Phone: ______

Street Address: ______ Other Phone: ______

City: ______ County: ______ State: ______ Zip Code: ______

Date of Birth: ______ Gender: ☐ Male ☐ Female ☐ Other Language: ______

Race: ______ Veteran: ☐ Yes ☐ No (Optional) Social Security Number: ______

Legal Status (check one): ☐ U.S. Citizen ☐ Student Visa ☐ Work Authorization ☐ Green Card ☐ Other ______

Date(s) of injuries: ______

How was injury acquired: ______

☐ Lack of oxygen to the brain ☐ Car or motorcycle accident ☐ Drug overdose ☐ Stroke

☐ Infection ☐ Fall ☐ Blow to the head ☐ Other: ______

Provide the name and address of the Doctor(s) and/or Hospital(s) who provided treatment for your brain injury.

Current/Primary Care Doctor: ______ Neurologist: ______

Address and phone number: ______

Address and phone number: ______

License Clinical Psychologist: ______ Other: ______

Address and phone number: ______

Other community services being received. Check all that apply.

☐ Community Service Board (CSB)/Mental Health Services

☐ Center for Independent Living (CIL)

☐ Department for Aging and Rehabilitative Services (DARS)

☐ Homeless Shelter Services

☐ Veterans Affairs Medical Center

☐ Medicaid Waiver Services

☐ Other: ______

Insurance

☐ Medicaid ☐ Medicare ☐ Private/Other: (Please list) ______

Rate each of the functional abilities of the person needing services. Check the appropriate box using the scale of 1-5.

1. Needs total help	2. Needs Significant Help	3. Needs Help and Supervision	4. Needs Supervision	5. Needs No Help

Paying bills, planning and keeping a budget ☐1 ☐2 ☐3 ☐4 ☐5	Time Management ☐1 ☐2 ☐3 ☐4 ☐5	Decision-making ☐1 ☐2 ☐3 ☐4 ☐5
Homemaking (chores, errands, etc.) ☐1 ☐2 ☐3 ☐4 ☐5	Movement ☐1 ☐2 ☐3 ☐4 ☐5	Using and arranging Transportation ☐1 ☐2 ☐3 ☐4 ☐5
Speech, Language, Communication ☐1 ☐2 ☐3 ☐4 ☐5	Self-care (bathing, dressing, etc.) ☐1 ☐2 ☐3 ☐4 ☐5	Learning new skills ☐1 ☐2 ☐3 ☐4 ☐5

Has the person needing services had any of the following?

History of substance abuse and/or alcohol abuse? ☐ Yes ☐ No

If yes, is the person actively participating in a program? ☐ Yes ☐ No

If yes, has the person completed a program? ☐ Yes ☐ No

When was the last time the person abused substance or alcohol? Date: ______

History of mental illness? ☐ Yes ☐ No

History of aggressive behavior/outburst? ☐ Yes ☐ No

Does the person have a history of arrest or a conviction for a felony? ☐ Yes ☐ No

Please explain each "yes": ______

Check the services for which assistance is needed:

- ☐ Brain Injury Education
- ☐ Transportation Solutions
- ☐ Problem Solving
- ☐ Finding a Place to Volunteer
- ☐ Budgeting
- ☐ Applying for Benefit Program such as SSI, DARS, SNAP, etc.
- ☐ Finding a Place to Live
- ☐ Homemaking
- ☐ Homeless Shelter Services
- ☐ Medication Management Routine
- ☐ Mental Health Referral
- ☐ Finding or communicating with a Healthcare Provider
- ☐ Finding Recreational Activities
- ☐ Coordination of School Support Services
- ☐ Social Interaction
- ☐ Preparing for a Job
- ☐ Finding and Acquiring Equipment
- ☐ Other: ______

Financial Information:

Financial information is needed for the following reasons:

1. To determine the person's ability to participate in payment for services offered which *may* require payment.
2. To better understand and communicate with donors about the financial needs of our clients. If this information is provided to a donor, it does not include client names.

Item	Amount
Number of people living in the household with the person needing services: (Include the person needing services)	
Total taxable income as listed on the income tax return of the person needing services:	**$**
Portion of income that is Social Security Income (SSI)	**$**
Portion of income that is Social Security Disability Insurance (SSDI)	**$**
Other non-taxable income such as Worker's Comp, Veteran's Disability, Child Support, other disability benefits.	**$**

By signing below the applicant or family has given permission for, and approval of, coordination of community services, and permission for the following: Brain Injury Services of SWVA may communicate information about the applicant with appropriate providers when a sentinel event occurs. Brain Injury Services of SWVA may, at its discretion, conduct a criminal background check on the applicant.

By signing this application, you acknowledge that Brain Injury Services of SWVA (BISSWVA) has the right to store personally identifiable information in their secured, electronic case management system.

BISSWVA also reserves the right to share certain necessary, required information, for the purposes of program and financial auditing, contract compliance monitoring, and management and outcome reporting with its funding partner, the Department for Aging and Rehabilitative Services (DARS). This specific information is stored in a secure location maintained by the Department for Aging and Rehabilitative Services (DARS). DARS does not have the authority to release any personally identifiable information to any other party without your consent.

Signature of person needing services: ______ Date: ______

Please return this application to: **Brain Injury Services of SWVA**, 3904-B, Franklin Road, Ste. B, Roanoke, VA 24014-3039 Fax: 540-344-9755

How did you hear about Brain Injury Services? Please list contact information.

☐ Referral ☐ Client ☐ Website ☐ Social Media ☐ Other: ______

Name of Referral: ______ Primary Phone: ______

Place of Business, if Professional Referral: ______

Relationship to Person Needing Services, if Personal Referral: ______

Street Address: ______

City: ______ State: ______ Zip Code: ______

Consent to Exchange Information

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, ______________________________, am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

____
(FULL PRINTED NAME OF CLIENT)

______________________________ ______________________________
(CLIENT'S ADDRESS) (CITY, STATE, ZIP)

______________________________ ______________________________
(CLIENT'S BIRTH DATE) (OPTIONAL: CLIENT'S SOCIAL SECURITY NUMBER)

My relationship to the client is:

☐ Self ☐ Parent ☐ Power of Attorney
☐ Guardian ☐ Other Legally Authorized Representative

I want the following confidential information about the client (**except drug or alcohol abuse diagnoses or treatment information**) to be exchanged:

☐ Assessment Information ☐ Medical Diagnosis ☐ Educational Records
☐ Financial Information ☐ Mental Health Diagnosis ☐ Psychiatric Records
☐ Medical Records ☐ Criminal Justice Records ☐ Psychological Records
☐ Employment Records ☐ Benefits/Services Needed, Planned, and/or Received
☐ Other Information (write in): ______________________________

I want: **Brain Injury Services of SWVA**, 3904 Franklin Road, Suite B, Roanoke, VA 24014

Staff Contact Person: ______________________________
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And the following other agencies to be able to exchange this information:

This consent is good until: ______________________________

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom It was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

Signature(s): ______________________________ Date: ______________
(CONSENTING PERSON OR PERSONS)

Person Explaining Form: ______________________________

Title: ______________________________ Phone: ______________

Witness Name: ______________________________ Witness Phone: ______________

Witness Address: ______________________________