Brain Injury Services of Southwest Virginia

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: Race: Language: Marital Status:

Gender: Have you ever served in the military? (Optional) Social Security Number:

☐ Male ☐ Female ☐ Other: ☐ Yes ☐ No Email Address:

Legal Status (check one):

☐ U.S. Citizen ☐ Green Card ☐ Student Visa ☐ Work Authorization ☐ Other_____

Date(s) of Injury_____

How was brain 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 & Phone Number: Address & Phone Number:

License Clinical Psychologist:_____ Other:_____

Address & Phone Number: Address & Phone Number:

Other community services being received. Check all that apply.

☐ Community Service Board (CSB) Mental Health Services ☐ Homeless Shelter Services

☐ Center for Independent Living (CIL) ☐ Veterans Affairs Medical Center

☐ Department for Aging and Rehabilitative Services (DARS) ☐ 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 significate 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

Have you ever had suicidal thoughts or attempted suicide/participated in self-injurious behaviors?.... ☐ Yes ☐ No

Are you currently homeless or anticipating being homeless within the next 30 days?..... ☐ 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 convictions of a felony?. ☐ Yes ☐ No

Please explain each "Yes" listed above:_____

Check the services for which assistance is needed:

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

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: Email:

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 CONSUMER)

_____
(CONSUMER'S ADDRESS) (CITY, STATE, ZIP)

_____
(CONSUMER'S BIRTHDATE) (CONSUMER'S SSN—OPTIONAL)

My relationship to the Consumer is:

☐Self ☐Parent ☐Power of Attorney

☐Guardian ☐Other Legally Authorized Representative

I want the following confidential information about the Consumer (**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 24014-3039

Staff Contact Person: Alicia Wright-Ellis, 3904 Franklin Rd, SW, Ste, B, Roanoke, VA 24014; 540-344-1200
(NAME AND ADDRESS OF STAFF CONTACT PERSON)

Name and address of referring agency and the following other agencies to be able to exchange this information:

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: _____ Expires: _____
(CONSENTING PERSON OR PERSONS) (1 year from date of signature)

Person Explaining Form: _____

Title: _____ Phone: _____

Witness Name: _____ Witness Phone: _____

Witness Address: _____

Note: This Information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.