

# **BRAIN INJURY SERVICES OF SWVA**

302 Second Street, Third Floor ~ Roanoke, Virginia 24011

Toll free phone 1.866.720.1008

Fax 540.344.9755 ~ info@bisswva.org

## **APPLICATION FOR SERVICES**

### **INFORMATION ABOUT THE PERSON COMPLETING THIS FORM**

Name: \_\_\_\_\_ Primary Phone: \_\_\_\_\_  
Place of Business, if professional referral: \_\_\_\_\_  
Relationship to person needing services, if personal referral: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### **INFORMATION ABOUT THE PERSON NEEDING SERVICES**

Name: \_\_\_\_\_ Primary Phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: *Male* \_\_\_\_\_ *Femal* \_\_\_\_\_ Language: \_\_\_\_\_  
Race: \_\_\_\_\_ Veteran: \_\_\_\_\_ (OPTIONAL) Social Security #: \_\_\_\_\_

### **How brain injury was acquired: (Date of brain injury \_\_\_\_\_)**

\_\_\_\_ Lack of oxygen to the brain    \_\_\_\_ Car or motorcycle accident    \_\_\_\_ Drug overdose  
\_\_\_\_ Stroke    \_\_\_\_ Infection    \_\_\_\_ Fall  
\_\_\_\_ Blow to the head    Other: \_\_\_\_\_

### **Which of the following providers can provide documentation of the person's brain injury:**

	<u>NAME</u>		<u>NAME</u>
Primary Care Doctor	_____	Licensed Clinical Psychologist	_____
Neurologist	_____		_____
Other:	_____		_____

### **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 of Rehabilitative Services (DRS)    \_\_\_\_ Medicaid Waiver Services  
Other: \_\_\_\_\_

### **Insurance:**

\_\_\_\_ Medicaid    \_\_\_\_ Medicare    \_\_\_\_ Private / Other: (please list) \_\_\_\_\_

### **Rate the functional abilities of the person needing services, using the following codes:**

5 - Totally independent    2 - Needs significant assistance  
4 - Needs supervision    1 - Totally dependent  
3 - Needs assistance and supervision  
\_\_\_\_ Paying bills, planning and keeping a budget    \_\_\_\_ Movement  
\_\_\_\_ Homemaking, such as laundry, shopping    \_\_\_\_ Self-care, such as bathing, dressing  
\_\_\_\_ Speech    \_\_\_\_ Decision making  
\_\_\_\_ Learning    \_\_\_\_ Transportation

**Has the person needing services had any of the following?**

History of substance 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                      \_\_\_\_\_ Finding a place to live                      \_\_\_\_\_ Finding recreational activities  
 \_\_\_\_\_ Transportation                                      \_\_\_\_\_ Homemaking                                      \_\_\_\_\_ Help with school  
 \_\_\_\_\_ Problem solving                                      \_\_\_\_\_ Finding a health care provider                      \_\_\_\_\_ Social interaction  
 \_\_\_\_\_ Finding a place to volunteer                      \_\_\_\_\_ Medication management                      \_\_\_\_\_ Preparing for a job  
 \_\_\_\_\_ Paying bills    \_\_\_\_\_ Mental health referral  
 \_\_\_\_\_ Finding and acquiring equipment                      \_\_\_\_\_ Applying for benefit programs such as SSI, DRS, etc  
 Other services needed: \_\_\_\_\_

**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)	
Number of people dependent on the income of 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)	\$
Portion of income that is Temporary Assistance for Needy Families (TANF)	\$
Portion of income that is General Relief (GR)	\$
Other non-taxable income such as Worker's Comp, Veteran's Disability, Child Support,	\$
Total cash assets including amounts in checking, savings, money market accounts; CDs and bonds maturing within 6 months; stocks; life insurance net cash value; mutual funds; and other liquid assets. Do not include KEOGH, SEP and IRAs.	\$
Annual expenses related to the needs of the person needing services:	\$

**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.**

Signature of person needing services, or their family: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE RETURN THIS APPLICATION TO:**  
 Brain Injury Services of SWVA  
 302 Second Street, Third Floor ~ Roanoke, Virginia 24011  
 Toll free phone 1.866.720.1008  
 Fax 540.344.9755 ~ info@bisswva.org