

Neuro-Resource Facilitation Application



Brain Injury Association of Vermont

92 South Main Street / P.O. Box 482 * Waterbury, Vermont 05676

Toll-free helpline: 1-877-856-1772 * Fax: 1-802-244-4005

E-mail address: braininfo1@biavt.org Web Page: www.biavt.org

[Date]

Dear:

Thank you for your interest in the Neuro-Resource Facilitation Program. The purpose of this program is to increase the independence and quality of life for Vermonters living with brain injuries.

Neuro-Resource Facilitation (NRF) assists individuals with an acquired or traumatic brain injury in setting goals and making informed choices for services and supports that may be helpful in meeting their individual needs. If you are accepted for program services, NRF staff will provide assistance in understanding and navigating systems of care, and in applying for services and supports needed to achieve their goals. **Very Important: we do NOT provide (or fund) direct services to individuals with brain injuries. We do help them find & apply for the most relevant programs and services to meet their needs, and assist in problem-solving any barriers that may arise.**

It is most appropriate for individuals who have functional independent living skills, and who are ready, able and willing at this time to assume some responsibility for following up with the referrals that we offer. We work collaboratively with any service providers or case managers who are already providing services to the individual, as well as family members and other support persons who wish to be involved (with the permission of the individual served).

To be eligible for the program, you need to be a legal resident of Vermont and be expected to benefit from the services.

If you have questions about the program, or need assistance in completing these forms, please call us toll free at 1-(877) 856-1772.

Sincerely,

Brain Injury Association of Vermont

<p>Enclosed: NRF Application Release of Information</p>
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Organization/Contact Person: _____ Phone: _____

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I need Assistance with: (check all that apply):

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Benefits | <input type="checkbox"/> Respite | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Organizing | <input type="checkbox"/> Advocacy | <input type="checkbox"/> Rehab Therapy |
| <input type="checkbox"/> Financial Assistance | <input type="checkbox"/> Counseling | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Medical Needs | <input type="checkbox"/> Legal Issues | <input type="checkbox"/> Employment |
| <input type="checkbox"/> Other: (what:)

_____ | | |

Name of person filling out form, if other than Survivor: _____
Relationship: _____ Phone number: _____

If you have questions you can call 877-856-1772

People who are deaf or hard of hearing can call the statewide relay service at 800-253-0192

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PROFESSIONAL AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize the Brain Injury Association of Vermont and
(Individual's Name/Guardian – please print)

The TBI Fund Committee to review 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:

Individuals Name (please print) Social Security # Date of Birth

I authorize the Brain Injury Association of Vermont and the TBI Fund Committee 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 _____. (If this line is left blank, consent shall expire upon client's termination of services from the program.)

Signature _____ Date _____
Self or Guardian, if applicable

Guardian's Phone Number: _____ (if applicable)

Individual's Mailing Address: _____

Individual's preferred Phone Number: _____

Individual's email address: _____