Community Brain Injury Consulting (CBIC) Application

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: jess@biavt.org Web Page: www.biavt.org

This is the application for the Community Brain Injury Consulting (CBIC) Program. The purpose of this program is to increase the independence and quality of life for Vermonters living with brain injuries.

CBIC staff assist individuals with an acquired or traumatic brain injury. We work with you and your 'Provider' in setting goals and making informed choices for services and supports that may be helpful in meeting your individual needs. Your 'Provider' may be a VocRehab or VABIR Counselor, a school team AT or nurse, a housing agency, a healthcare provider, etc.. What the CBIC staff person will provide is consulting with you and your Provider. Any contact after the initial consultation can be done by phone as part of our Helpline service.

Very Important: **Additional support for individuals with brain injury outside of the BIAVT's CBIC services will be by agreement between the provider, individual with brain injury, the BIAVT, along with the identification of funding sources to support that activity.**

We work collaboratively with any service providers or case managers who are already providing services to you, as well as family members and other support persons who you wish to be involved.

If you have questions about the program, or need assistance in completing these forms, please call us toll free at 1-(877) 856-1772. The Helpline is staffed 9-4 on weekdays and you can leave a message if no one is available to take your call.

Sincerely,

Brain Injury Association of Vermont

Enclosed:
CBIC Application
Release of Information

Community Brain Injury Consulting (CBIC) Application

Date: _____________

How did you hear about this program? (check all that apply):

___ Current Care Provider ____ Voc. Rehab counselor ___ State TBI Program

___ BIA-VT staff ___website ___ 211__ Other-please list_______________

Name: ____

Address ____

Town: ______________________ State: ______________ Zip: ______________

Phone Number: _______________ Phone Type: Home Work – Mobile - Other

Phone Number: _______________ Phone Number________________________

E-mail Address: ____

Date of Birth: ____________

Ethnicity (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check all that apply)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

How did you receive your injury? ____

____

____

Date of your injury: _________

How old were you at the time of your injury: ___________

___Male Yes / No Time spent in coma?

___Female _______ How long in coma?

Do you have (or had) Seizures? Yes or No

Have you ever served in the military: Yes___No___

Employed currently: Yes ___ No ___

<u>Benefits currently receiving:</u> (please circle yes or no)

Private Insurance:	Yes or No	SSI:	Yes or No
Medicaid:	Yes or No	Medicare:	Yes or No
SSDI:	Yes or No	State TBI Program:	Yes or No

What other services are you currently receiving? Please list organization(s), contact person(s) and their phone number(s).

Organization/Contact Person: ______________________________ Phone: ____________

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Organization/Contact Person: ___________________________________ Phone:_____________

Organization/Contact person: ___________________________________ Phone: _____________

<u>I need Assistance with:</u> (check all that apply):

☐ Benefits	☐ Respite	☐ Housing
☐ Organizing	☐ Advocacy	☐ Rehab Therapy
☐ Financial Assistance	☐ Counseling	☐ Transportation
☐ Medical Needs	☐ Legal Issues	☐ Employment

☐ Other: ____

____

____

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

PROFESSIONAL AUTHORIZATION
FOR RELEASE OF INFORMATION

I ____________________________________authorize the Brain Injury Association of Vermont (Individual's Name/Guardian – please print) to review copies of all medical, hospital or other pertinent records or information in order to assist in consultation for:

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

I authorize the Brain Injury Association of Vermont 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 I provide to you to assist in seeking services and payments for such services.

I also give permission to discuss any medical records or information with the following individual(s):
____

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.)

I further understand that I may revoke this authorization at any time by notifying BIAVT in writing at PO Box 482, Waterbury, VT 05676, except to the extent that it has already been relied upon. If this option is selected your involvement with the NeuroResource Facilitation program would be able to continue, however services would be very limited.

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: ___________________________________