Brain Injury Alliance COLORADO

Application for Case Management Services

Applicant Information *(person applying for services)*

Last Name: _____ **First Name:** _____

Gender: ☐ M ☐ F **Date of Birth:** _____/_____/_____

Race/Ethnicity *(Optional)*: ☐ African American/Black ☐ American Indian/Alaskan ☐ Asian ☐ Caucasian/White ☐ Hispanic/Latino ☐ Pacific Islander ☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Sig. Other Military Status: ☐ Active ☐ Veteran ☐ N/A

Is English your primary language? ☐ Yes ☐ No If no, would you like an interpreter? ☐ Yes ☐ No

If not English, what is your primary language? _____

Preferred Phone: _____ ☐ Home Phone ☐ Cell Phone ☐ Someone Else (Page 3)

Secondary Phone: _____ ☐ Home Phone ☐ Cell Phone ☐ Someone Else (Page 3)

Email: _____

Preferred Type of Communication: ☐ Phone ☐ Email ☐ Other: _____

Street Address: _____ **Check if Homeless:** ☐
Apt. # (if applicable)

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Have you ever been convicted of a violent crime or felony? *(conviction will not exclude you from program)* ☐ Yes ☐ No

If yes, explain: _____

Annual Income Range: *Optional - Client income has no impact on eligibility for services with BIAC. This information is used to help guide clients to services and to understand the economic impact that brain injury is having on individuals.*

☐ Under $12,000 ☐ $12,000 - $19,999 ☐ $20,000 - $34,999 ☐ $35,000 - $49,999 ☐ $50,000 - $74,999 ☐ $75,000+

Description of Injury *(Please include all acquired brain injuries. If you don't know specific dates, use your best guess.)*

Date(s) of Brain Injury:

_____/_____/_____ Cause of Injury: _____
Month Day Year

_____/_____/_____ Cause of Injury: _____
Month Day Year

_____/_____/_____ Cause of Injury: _____
Month Day Year

Symptoms *(please check all that apply)*:

- ☐ Learning
- ☐ Short Term Memory
- ☐ Attention
- ☐ Fatigue
- ☐ Reasoning
- ☐ Gait Issues
- ☐ Balance Issues
- ☐ Vision Issues
- ☐ Noise Sensitivity
- ☐ Judgment
- ☐ Behavior
- ☐ Social Skills
- ☐ Slowed Cognitive Processing
- ☐ Light Sensitivity
- ☐ Fine Motor Skills

FORM A: Authorization to Release and Share Protected Health Information *(PHI)*

Is there anyone, other than applicant, in your extended support network – such as friends, family, legal guardians or your power of attorney (POA) – that you would like us to be able to talk to about your application? If not, that's ok.

I hereby consent to and authorize the Brain Injury Alliance and its employees, to obtain from and share individually identifiable protected health information with the individuals/organizations listed below. I understand that this authorization is voluntary. I understand that if the individuals/organizations authorized by this release to receive or share my information is not a health plan or health care provider, the released information may be subject to re-disclosure and no longer protected by federal privacy regulation.

Applicant Information *(person applying for Brain Injury Alliance Case Management Services)*

Name: _____ Date of Birth: _____/_____/_____

Secondary Contacts *(individuals/organizations authorized to release & share information, for example friends, family members, guardians or POA)*

For youth applicants, please list parents info here.

Name: _____ Name: _____ Name: _____

Phone: _____ Phone: _____ Phone: _____

Relationship: _____ Relationship: _____ Relationship: _____

Purpose of Information Disclosure: *Case Management Services through the Brain Injury Alliance of Colorado*

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that unless I specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose, or for up to one year from date of signature. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section found below. I further understand that any release of information prior to the rescinded date is legal and binding. This authorization will expire two (2) years from the date of signature on this application **unless you tell us that it should expire sooner.** I also understand that I may refuse to sign this authorization and that my services will not be affected if I do not sign. I further understand that I may request a copy of this signed authorization and that I may see and copy the information described on this form if I ask for it.

Signature: _____ Date: ____/____/____ Witness: _____
(Applicant/Guardian/POA Signature) *(If Required)*

Revocation Section *(Unless you would like to TAKE AWAY the above privileges, please do not sign.)*

I no longer authorize the above named parties to release and share my Protected Health Information.

Signature: _____ Date: ____/____/____ Time: _____
(Applicant/Guardian/POA Signature)

Youth Education Consultation Release *(for those in school)*

I acknowledge that information about this applicant/student may be forwarded to or discussed with the student's school district of attendance or the student's school building and/or instructor to provide Case Management Services and Education Consultation.

Signature: _____ Date: _____/_____/_____
(Applicant/Guardian/POA Signature)

FORM B: Medical Records Request *(Authorization for Disclosure of Protected Health Information)*

If you have records that show a diagnosis of brain injury please include it with your application. We can accept records from the following types of providers: MD, DO, PA, NP, or Clinical Psychologist (Ph.D., Psy.D., Ed.D). If you don't have medical records to send in, that's ok. We can request records for you from a doctor, hospital, or another type of provider using this page.

I authorize the following facility to release the health information of the individual named below:

Name of Facility/Doctor: _____

Your Name: _____

Dates of Treatment: _____

Date of Birth: _____/_____/_____

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Organization: Brain Injury Alliance of Colorado, Attn: Case Management
Address: 1325 S. Colorado Blvd, Suite B-300, Denver, CO 80222
Phone: 303-355-9969 | Fax: 303-355-9968

The type and amount of information to be disclosed is as follows:

All documentation of brain injury diagnosis, including discharge summaries, physicians' reports, and neuropsychological assessments from all dates of treatment

The above information is to be used for:

Eligibility determination, continuation of care, and brain injury case management support through the Brain Injury Alliance of Colorado.

I understand this authorization will expire, without my express revocation, upon two (2) years of date of signature. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on obtaining my authorization. I understand that any disclosure of my information carries with it the potential for re-disclosure and once the information is disclosed, it may no longer be protected by federal HIPAA confidentiality rules.

Signature: _____ **Date:** _____/_____/_____
(Patient or Authorized Personal Representative Signature)

Personal Representative's Name ***(print)*****:** _____ **Date:** _____/_____/_____

Relationship: _____
(Please provide a copy of paperwork such as POA or Guardianship if applicable)

This authorization reflects the requirements of HIPAA, 45 C.F.R. § 164.508.

FORM C: Acknowledgement of Receipt of Notice of Privacy Practices and Appeal & Grievance Policy

Name: _____ **Phone:** _____

Address: _____

I have received a copy of the Brain Injury Alliance of Colorado's ***Notice of Privacy Practices***.
(This document is either included with this application as a separate packet or it can be found online at BIAColorado.org/Privacy)

Signature: _____

Date: _____/_____/_____

I have received a copy of the Brain Injury Alliance of Colorado's ***Appeal & Grievance Policy***.
(This document is either included with this application as a separate packet or it can be found online at BIAColorado.org/Appeal_Grievance)

Signature: _____

Date: _____/_____/_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prohibited us from obtaining acknowledgement
- ☐ Other *(Please Specify)*: _____

_____

_____

FORM D: Program Agreement

What You Can Expect and What We Expect from You

We are glad you are considering applying for case management services through the Brain Injury Alliance of Colorado (BIAC). Should you decide to complete the application and be found eligible for case management services at BIAC, it is important that you have a clear understanding of both what you can expect from BIAC and what is expected of you to participate in these services. BIAC Case Management services strives to connect people who have been affected by all forms of acquired brain injury with resources that best fit their unique situation. Once your application has been approved, we will be excited to start working with you to help get access to available services and supports when needed.

Together we will work to identify goals or areas of needs where you would like to see change. After these goals and areas of need have been identified, you and BIAC's Case Management Staff will work as partners to move forward. Together, available options will be explored and considered. Typically, this is done by phone but we also have case managers available to meet you in person should the need arise.

The role of your Case Manager is to be an ally and to connect you with providers, supports, and services that may be able to meet your needs or help you to achieve your goals. You and your case manager will establish a schedule of calls depending on the need. The frequency might increase or decrease depending on the particular situation.

It is important to note that the role of BIAC is to provide case management support. This means the case managers will help you to identify and secure resources based on your needs/goals, for example, if you need housing, the Case Managers will help connect you to housing specialist. If you require legal or medical support they will connect you to those specialists. BIAC Case Managers are not medical or legal professionals. Therefore they cannot provide legal advice/counsel nor are Case Managers able to assess or treat any medical needs identified. Again, the role of the Case Manager is to connect you to the professionals who specialize in those areas.

Expectations

Below are what you can expect from BIAC Case Managers as well as what we expect from you to ensure that this partnership is as beneficial and successful as possible.

- Case Managers will treat you with respect and expect you to do the same. BIAC understands that brain injury can lead to difficulties with impulse control and anger management. However, if you are disrespectful by yelling, being verbally abusive, or using discriminatory language (racial, sexist or otherwise), it is important that you understand your services will be put under review and a behavior contract may be implemented. If the behavior is not corrected, services may be terminated.
- Positive outcomes depend on active participation and open communication. You can expect that the BIAC Case Manager will follow through and communicate with you in a timely manner based on your needs. We expect that you will also be responsive and timely in your communication. Services may be ended if you do not engage in communication or actively participate in services with your Case Manager. Active participation by you and your case manager is the only way to ensure successful outcomes.
- Please note that there are grievance and appeal processes in place should that need arise.

Please note: If you require accommodations (including aids or services for effective communication) to participate in case management services, please inform a BIAC staff person.

I understand the expectations of me and what I can expect from BIAC.

Signature: _____ **Date:** _____/_____/_____

(Applicant/Guardian/POA Signature)

How did you hear about Brain Injury Alliance of Colorado? _____

_____

I'm interested in the following parts of Case Management:

- ☐ Resource Navigation
- ☐ Benefit Assistance
- ☐ Help with Paperwork
- ☐ Social & Entertainment Opportunities *(when available)*
- ☐ Recreation Programs
- ☐ Classes and Activities
- ☐ Educational Materials about Brain Injury

Who We Are

The Brain Injury Alliance of Colorado is the go-to resource for help and services for survivors of an injury to the brain, their families, and providers.

What We Do

Client Programs

- Case Management
- Recreation Programs
- Therapeutic Music and Art Classes
- Emergency Utility Bill Assistance
- Seminars, Classes, and Workshops
- Support Groups
- Online Resource Directory
- Education Support

Professional Programs

- Brain Injury Professional Networks
- Professional Conference
- Community Outreach and Education

Other Programs & Fundraisers

- Pikes Peak Challenge Fundraising Event
- Public Policy
- Quarterly Newsletters
- Reinhardt/Bruno Golf Tournament

Brain Injury Alliance COLORADO

Where to Send Everything Once You're Ready:

Via Mail

Brain Injury Alliance of Colorado
Case Management Program
1325 S. Colorado Blvd, Ste B-300
Denver, CO 80222

Via Email

CaseManagement@BIAColorado.org

Via Fax

Fax (303) 355-9968

For Any Questions, Please Contact Us:

(303) 355-9969 or 1 (800) 331-3311

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(formerly the Colorado Brain Injury Program)