To applicants of the Brain and Spinal Injury Trust Fund Commission,

Thank you for your interest in applying for an award. Your packet contains:

- **Checklist Packet** - contains everything you need to know to begin this process. (amounts you can request, documentation needed, and MORE)

- **Application Packet** - Please fill out the entire application completely. Incomplete pages will delay the process.

If you have questions about how to fill out the application please call the Commission office at 404-651-5112 and ask to speak to an application assistant. Thank you for allowing us to support you in your endeavors to be independent and successful. When you are ready to submit your application please send to:

Brain & Spinal Injury Trust Fund Commission
2 Peachtree St. NW, Suite 26-426
Atlanta GA 30303
Phone: 404-651-5112 or 1-888-233-5760
Fax: 404-656-9886
dph-info-bsitf@dph.ga.gov

⌘You may also apply online at www.bsitf.state.ga.us⌘

NOTE:

- **There is a $10,000 distribution cap unless you are applying for modified van, modified pickup truck, or modified SUV (See policies for new changes).** If you are a returning applicant and have been previously awarded $10,000 or more you are no longer eligible to apply.

- **There is a $15,000 distribution cap ONLY for a modified van, modified pickup truck, or modified SUV.**

- Keep this packet for reference throughout the application process.

Be sure to make a copy of your application and supporting documents to keep for your records.

TABLE OF CONTENTS

Requests UP TO $15,000

- Modified vehicles……..……19
- Vehicle modifications……..…..20

IMPORTANT!
Please review before submitting your application

This checklist contains a detailed list of the documentation you will need to complete your application. **Every applicant needs to provide the following:**

1. Full application, with complete answers to each question.
2. All signature pages of application (submit a hard copy within 7 days if the application is being submitted electronically).
3. Medical documentation or letter on letterhead from a physician, medical practitioner, hospital, clinic or other medical or medically related facility, or insurance company, verifying 1) WHAT your injury is, 2) HOW your injury occurred 3) the DATE of your injury occurred. Letters that fail to indicate all three items will not be sufficient.
4. Proof of Georgia residency (see enclosed list of acceptable documentation).
5. Proof of United States Citizenship (See enclosed citizenship affidavit with instructions). **Common documents include**: birth certificate, passport, military ID. (A Georgia driver's license does NOT qualify as proof of U.S. Citizenship)
6. Copies of written denials from other sources if applicable (i.e. private insurance, Medicaid, Medicare, waivers, etc.).
7. One (1) cost quote or estimates from each vendor, company, or organization (provider) that will provide **each** requested good or service(where applicable)
8. Additional documentation outlined under the specified category request for EACH good(s) or service(s) requested in the application packet.

Helpful Hint:

- Think about what you are requesting and find the category using the table of contents provided.

- Use the table of contents on the next page to help you find the documentation needed for your specific request(s).

FREQUENTLY ASKED QUESTIONS

1. **How do I know if I am eligible to apply for a grant?** Eligible individuals must meet the following criteria:
   - **a.** Resident of Georgia at the time of application
   - **b.** Citizen of the United States
   - **c.** Sustained a traumatic brain or spinal cord injury. See definitions below:

"Brain Injury" means a traumatic injury to the brain (cranio-cerebral head trauma), not of a degenerative or congenital nature, but arising from blunt or penetrating trauma or from acceleration-deceleration forces that is associated with any of these symptoms or signs attributed to the injury: decreased level of consciousness, amnesia, other neurologic or neuropsychologic abnormalities, skull fracture, or diagnosed intracranial lesions. These impairments may be either temporary or permanent and can result in a partial or total functional disability.

"Spinal cord injury" means a traumatic injury to the spinal cord, not of a degenerative or congenital nature, but arising from blunt or penetrating trauma or from acceleration-deceleration forces, resulting in paraplegia or quadriplegia, which can be a partial or total loss of physical function.

NON-eligible injures include:

(a) Individuals who have had a CVA (cerebral vascular accident/stroke); or
(b) Spinal cord dysfunction for which there are no known or obvious " injuries" to the intracranial central nervous system; or
(c) Progressive dementias and other mentally impairing conditions; or
(d) Depression and psychiatric disorders; or
(e) Mental retardation and birth-related disorders; or
(f) Neurological degenerative, metabolic, and other conditions of a chronic, degenerative nature; or
(g) Anoxic or hypoxic episodes, allergic reactions, toxic substance reactions or any other inflammatory infections or acute medical incidents.

2. **How do I apply for a grant?** Complete an application and submit it and other required documents to the Commission. You may contact the Commission office for an application at 1-888-233-5760 or 404-651-5112. You may also apply online at www.bsitf.state.ga.us.

FREQUENTLY ASKED QUESTIONS

3. Is the Trust Fund an entitlement?

No. A grant from the Trust Fund is not a permanent source of funding for an individual. An eligible application is not a guarantee of receiving funds.

4. How long will it take to review my application?

(a) Once staff deems your application complete (all requested documentation received) the application is date stamped and is placed in the queue with all other applications received in date stamp order. There is normally a waiting list that can last from three to nine months depending on the availability of funds and the nature of your request.

(b) If your application is incomplete when it arrives, it may be necessary to contact you to request additional information, which will prolong this process.

(c) The final step of the process is for the Commission to send its recommendations for funding to the Governor for final approval. This is required by our legislation.

5. If I am approved for a disbursement, when will I receive the funds?

(a) Once you have been approved for a disbursement, you will receive a Provider Selection form to complete and send back to us. This form indicates the provider you have chosen.

(b) The provider you have chosen will then receive a letter of authorization to provide the good or service. The provider must submit an invoice to us for the good or service rendered.

(c) Upon receipt of invoice, a check will be distributed within Thirty Days - State of Georgia policy is net 30 days for payment of invoices.

(d) If you have not begun to spend your award within one year of the grant award date your grant award tor that specific request will be rescinded.

(e) You may reapply at a later date for rescinded items if allowed by rule.

FREQUENTLY ASKED QUESTIONS

6. How much money can I apply for?

The Commission has set the total **maximum** distribution award cap at $10,000 per eligible applicant. This cap is **retroactive** to all previous distribution recipients. Once the maximum amount is reached the applicant is no longer eligible to apply. You may request up to the following amounts for the following categories.

(a) **Computers** - up to $750
(b) **Dental** - up to $1,000 in a twelve-month period
(c) **Recreation –** up to $2,500 in a twelve-month period
(d) **Alternative Transportation-** up to $5,000
(e) **Assistive Technology -** up to $5,000
(f) **Durable Medical equipment / wheelchair -** up to $5,000
(g) **Health and wellness -** up to $5,000
(h) **Vision / hearing services -** up to $5,000
(i) **Vocational support -** up to $5,000
(j) **Medical, Rehabilitative, Therapeutic services -** up to $10,000
(k) **Personal Support Services -** up to $10,000
(l) **Non-modified vehicle -** up to $10,000 (a single purchase)
(m) **Home Modifications -** up to $10,000
(n) **Modified Vehicles -** up to $15,000 (a single purchase)
(o) **Vehicle modifications -** up to $15,000
(p) **All other requests** - up to $5,000 * (the Commission may limit request amounts for other types of requests).

Please note - All distributions are subject to the availability of appropriated funds.

7. Is there anything I CANNOT apply for? The Commission does not provide funding for:

a) any type of emergency housing (e. g. down payments, rent, mortgage/loan payments, or repairs);
b) vehicle repairs
c) internet service;
d) furniture/appliances(except for front-loading washers and dryers, accessible stoves/ovens;
e) legal expenses (e.g. court-mandated fees, fines or attorneys fees);
f) taxes or tax penalties (e.g. sales, ad valorem, (property) or income taxes);
g) any medications (prescriptions) or medical insurance premiums

h) moving expenses, vacations or airfare

FREQUENTLY ASKED QUESTIONS

8. **Do I have to pay taxes on my award?** **YES**. The Brain and Spinal Injury Trust Fund Commission is a tax-exempt agency and does not reimburse sales tax. The recipients is responsible for all sales taxes.

9. **Will the check be made out to me or to the provider?** The check will be made out to the provider / vendor.

   Can the Trust Fund reimburse me for past expenses? **No.** The Trust Fund does not pay for and will not reimburse you for goods and services that you paid for prior to your application being approved.

10. **If I have applied before and want to apply again, do I have to complete the entire application again?** **YES.** You will need to complete a new application with information related to your new request.

11. **Do I have to use a specific provider or can I choose my own?**
    You may choose your own provider. The Commission may seek basic information about the provider's ability to deliver the good or service.

12. **How many quotes for my item or service do I need to submit with my application?**
    Applicants must include a minimum of one quote for each item or service requested (where applicable). Your application will not be considered complete without the quotes from vendors. (note – some items such as computers, dental services or vehicles do not require a quote during the application process. If awarded you will be required to show a quote or invoice before purchase.)

13. **How do I apply for home modifications?**

    (a) The Brain & Spinal Injury Trust Fund Commission is working with the Department of Community Affairs (DCA) to process requests for home modifications.

    (b) If you are requesting a home modification Commission staff will refer eligible applicants to DCA. You may have to work with DCA's list of approved vendors.

    (c) Home modification requests are eligible for up to **$10,000.**

14. **How can I reach the Commission office?**

Brain & Spinal Injury Trust Fund Commission
2 Peachtree Street NW
Suite 26-426
Atlanta, GA 30303

BEFORE YOU APPLY TO THE BRAIN & SPINAL INJURY TRUST FUND COMMISSION
(FORM KZ 02/01/2017)
Phone: 404-651-5112 or 1-888-233-5760
Fax: 404-656-9886
Email us: dph-info-bsitf@dph.ga.gov

GEORGIA RESIDENCY REQUIREMENTS

Please include proof of **Georgia residency** with your completed application.

NOTE:

- All documents must show your name and your current residential address
- Applicants may cross-out account balances and/or account numbers from documents presented as proof of residency

Proof of Georgia Residency - can consist of a copy of any one of the following:

1. Non-expired Georgia driver's license, permit or identification card
2. Utility bill issued within the last sixty (60) days for services installed at your residential address (ex. water, sewer, gas, electricity, cable/satellite TV, internet, telephone/cell phone, or garbage collection)
3. Financial statement for bank/credit union account, investment account, credit card account, or loan/credit financing issued within the last sixty (60) days
4. Current, valid rental contract/agreement and/or rent payment receipts issued within the last sixty (60) days (includes rental agreement/leases for a home, apartment, mobile home, dorm, extended stay motel, retirement/assisted living home, and letter from a shelter)
5. Employer verification, including, but not limited to, one of the following:
    - Paycheck or paycheck stub
    - Letter from your employer on company letterhead
    - W-2 for current or preceding calendar year
    - Military orders
6. For minors and dependents, unexpired GA driver's license, permit, or ID card issued to parent, guardian, or spouse residing in same household; **AND** School record or transcript, report card; (if in school)
7. Health insurance statement or explanation of benefits (EOB) for claim or a health care bill/invoice
8. State of Georgia or Federal income tax return or refund check for current or preceding calendar year
9. Social Security documentation including Social Security Annual Statement for current

or preceding calendar year, Numident record, or Social Security check. For more information, please go to www.ssa.gov/mystatement/

GEORGIA RESIDENCY REQUIREMENTS - continued

10. Statements for Federal, State, and Local assistance programs including Medicare, Medicaid, unemployment insurance claims, or WIC
11. School record or transcript, report card, student loan application, or form DS-1 for current or preceding calendar year
12. Homeowners insurance policy or premium bill for current or preceding calendar year
13. Mortgage, payment coupon, deed, escrow statement or property tax bill for current or preceding calendar year
14. Voter Registration Card
15. Auto-Insurance Policy with Applicant's name and address
16. Auto-Registration with Applicant's name and address
17. Unexpired TWIC card (Transportation Worker Identification Credential)
18. Unexpired Firearms License (Gun Permit)
19. Unexpired Merchant Marine License
20. Other Documents issued by the Federal/State/Municipal Government
21. Dept of Corrections Residency Verification Form (DS-752)
22. Georgia or Federal Income Tax Return or Refund Check for the current or preceding calendar year

BEFORE YOU APPLY TO THE BRAIN & SPINAL INJURY TRUST FUND COMMISSION
(FORM KZ 02/01/2017)

U.S. CITIZENSHIP DOCUMENTATION REQUIREMENTS

Instructions For Completing Affidavit Required To Apply To The Brain & Spinal Injury Trust Fund Commission (v1.3.2012)

Dear Applicant: **PLEASE TAKE THIS ENTIRE PACKET WITH YOU TO THE NOTARY PUBLIC**

In order to apply for a grant from the Brain and Spinal Injury Trust Fund Commission (BSITFC), Georgia law requires every applicant to complete an affidavit (sworn written statement) before a Notary Public that establishes that the applicant is a citizen of the United States of America. Your application may be withdrawn or an award may be revoked if it is determined that you have provided false information. Please see the instructions listed below.

1. **Review the attached list of Secure and Verifiable Documents** under O.C.G.A. §50-36-2 which follows these instructions. This list contains a number of identification sources to choose from that are considered secure and verifiable that you can use to establish your U.S. citizenship, such as a birth certificate or a U.S. passport.

Locate **one** original document on the list to bring to the Notary Public to establish your identity. Note – some of the items on the list are crossed out – those items are **NOT** eligible for application to the BSITFC

2. **Fill in the blanks on the attached Affidavit**, above the signature line only—BUT DO NOT SIGN THE AFFIDAVIT at this time. (You will sign the affidavit in front of the Notary Public.) **Fill in the name of the secure and verifiable document** (for example, birth certificate or U.S. passport) that you will be presenting to the Notary Public as proof of your U.S. citizenship.

CAUTION: Only U.S. citizens may apply for a BSITFC grant. If you are not a U.S. citizen you are not eligible to apply.

3. **Bring your affidavit and the identification** you selected (from the attached list of Secure and Verifiable Documents) to appear before the Notary Public. (Public libraries and banks often have a Notary Public)

4. **Show the Notary Public** your secure and verifiable identification and state under oath in the presence of the Notary Public that you are who you say you are and that you are in the United States lawfully. Then sign your name.

5. **Make certain** that the Notary Public signs and dates the affidavit and writes when the notary commission expires. **PLEASE MAKE SURE YOU HAVE FILLED IN THE NAME OF THE SECURE AND VERIFIABLE DOUCMENT YOU SHOWED THE NOTARY PUBLIC**

6. **Make a copy** of the affidavit and the identification that you presented to the Notary Public for your own records.

7. Include the **ORIGINAL SIGNED AFFIDAVIT** document you presented to the Notary Public with your BSITFC application.

O.C.G. A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for a(n) grant [*type of public benefit*], as referenced in O.C.G.A. § 50-36-1, from the Brain & Spinal Injury Trust Fund Commission [*name of government entity*], the undersigned applicant verifies one of the following with respect to my application for a public benefit:

1)_____I am a United States Citizen.

2)_____I am a legal permanent resident of the United States.

3) _____I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is:_____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G. A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:

_____.

[***Must be filled out- See attached list for acceptable documents***]

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in_____(city),_____(state).

_____

_____

Signature of Applicant

Printed Name of Applicant

_____

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
____DAY OF_____, 20 _

NOTARY PUBLIC
My Commission Expires:

Before you apply to the Brain & Spinal Injury Trust Fund Commission….

(FORM CL 7-01-16)

USE THESE TWO PAGES TO DETERMINE WHAT DOCUMENTATION TO PRESENT TO THE NOTARY

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2012 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Certification of Report of Birth issued by the United States Department of State (Form DS-1350) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-362(b)(3); 6 CFR § 37.11]

Before you apply to the Brain & Spinal Injury Trust Fund Commission….

(FORM CL 7-01-16)

CATEGORY REQUESTS - BELOW $5,000

NOTE: Recipients of distributions are responsible for **any and all taxes**, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

❖ Computer request – up to $750 (once every 4 years)

Documentation required:

1) Completed application

Note: Computers limited to a cost of up to $750. An additional $100 may be requested for a printer or scanner and $200 for software related to the applicant's disability

--If adaptive equipment is necessary an assistive technology (AT) assessment may be requested.

--The Commission will not pay for warranties or internet service.

--Quotes/invoices are not required during the application process but will be required if you are awarded

❖ Dental services request – up to $1,000 (within a 12 month period)

Documentation required:

1) Completed application

Note: Awards for dental services are capped at $1,000 annually and preventive services are allowed.

Quotes/invoices are not required during the application process but will be required if you are awarded

❖ Recreation / hobbies services or equipment requests – up to $2,500 (within a 12 month period)

Documentation required:

1) Completed application

2) A cost quote reflecting the amount of funding being requested, timeframe, or length of time for services.
The applicant must demonstrate that the goods and services requested:

(i) Allow for the person to be an active member of the community; **(ii)** Promote health and well-being; and **(iii)** Allow for independence in an activity the applicant would not be able to participate in otherwise.

Before you apply to the Brain & Spinal Injury Trust Fund Commission….

(FORM CL 7-01-16)

CATEGORY REQUESTS - UP TO $5,000

NOTE: Recipients of distributions are responsible for **any and all taxes**, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

❖ Alternative Transportation requests – up to $5,000

Documentation required:

NOTE: Alternative transportation includes, but is not limited to cab services and public transportation.

1) Completed application

2) One (1) cost quote

3) Any other additional documentation that may be required by Trust Fund staff.

❖ Assistive technology (AT) requests – up to $5,000

Documentation required:

1) Completed application

2) One (1) cost quote

3) Assistive technology (A.T.) assessment which outlines how the technology meets your particular needs **OR** a recommendation from a credentialed therapist practicing in the SCI/TBI field (needed only for environmental control units, communication devices, computer software, etc)

❖ Durable medical equipment / wheelchair request – up to $5,000

Documentation required:

1) Completed application

2) One (1) cost quote

3) A prescription for the equipment **OR** a recommendation by a therapist for the specific equipment being requested.

4) Copies of written denials (if available) from Medicaid, Medicare, private insurance, or other sources. The Trust Fund must be the payer of last resort and reserves the right to deny request if another payer is identified.

❖ Health and wellness service requests – up to $5,000

Documentation required:

1) Completed application

2) A cost quote reflecting the amount of funding being requested, detailing:
   a. the cost of services
   b. frequency of services
   c. and length of time for services

❖ Vision / hearing services requests – up to $5,000

Documentation required:

1) Completed application

2) A letter from physician stating that requested service is directly related to your injury.

3) One (1) cost estimate for services

4) Copies of written denials (if available) from Medicaid, Medicare, private insurance, or other sources. The Trust Fund must be the payer of last resort and reserves the right to deny request if another payer is identified.

❖ Vocational support requests – up to $5,000

Documentation required:

1) Completed application

2) One (1) cost estimate for services

Before you apply to the Brain & Spinal Injury Trust Fund Commission….

(FORM CL 7-01-16)

CATEGORY REQUESTS - UP TO $10,000

NOTE: Recipients of distributions are responsible for **any and all taxes**, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

❖ Medical, rehabilitative or therapeutic services request – up to $10,000

Documentation required:

1) Completed application

2) Letter from a physician, verifying the need for the requested service or product

* For rehabilitative, neuropsychological, and other therapies:
(1) expected length of time for services, and frequency of services from an accredited medical professional (this information can be included on your quote)

(2) One (1) cost estimate for services itemized to reflect the amount of request for funding and services to be provided

(3) Copies of written denials (if available) from Medicaid, Medicare, private insurance, or other sources. The Trust Fund must be the payer of last resort and reserves the right to deny requests if another payer is identified.

❖ Personal support services /attendant care /respite requests – up to $10,000

Documentation required:

1) Completed application

2) A cost quote reflecting the amount of funding being requested, detailing all of the following:

1) the cost of services per hour and/or per day
2) frequency of service
3) length of time for services
4) name, address, phone number of the vendor

3) Copies of written denials (if available) from Medicaid, Medicare, private insurance, or other sources. The Trust Fund must be the payer of last resort and reserves the right to deny requests if another payer is identified.

Before you apply to the Brain & Spinal Injury Trust Fund Commission….

(FORM CL 7-01-16)

❖ Vehicle (non-modified) requests – up to $10,000

Documentation required:

For non-modified vehicles and non-modified vans

1) Completed application

2a) If applicant is **NOT** the driver: A current valid Georgia driver's license (a provisional driver's license is not acceptable)

2b) If the **applicant IS** the driver: A current valid Georgia driver's license **renewed AFTER** the date of injury (a provisional driver's license is not acceptable)

3) If the **applicant IS** the driver: Copy of a driving evaluation **OR** a note on physician letterhead signed by a physician, stating that the applicant is able to drive

Note:
The Commission will not consider replacement of operable vehicles.

The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible to the applicant.

The Commission will not pay for a vehicle with a salvage title vehicle or from a member of the applicant's household.

If you have already been awarded a vehicle of any type by the Brain & Spinal Injury Trust Fund Commission you are NOT eligible to apply for another one.

Vehicle quotes/invoices are NOT required during the application process but WILL be required if awarded.

Before you apply to the Brain & Spinal Injury Trust Fund Commission….

(FORM CL 7-01-16)

CATEGORY REQUESTS - UP TO $10,000

NOTE: Recipients of distributions are responsible for **any and all taxes**, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

❖ Home modification requests – up to $10,000

Documentation required:

1) Completed application

NOTE: The BSITFC works with the Department of Community Affairs (DCA) to administer the home modification program. Please complete the application and staff will follow-up with you regarding the next steps for home modification requests.

Requests for home modifications CANNOT increase the square footage of the home.
Requests for home modifications CANNOT be combined with other requests.

❖ Modified Vehicle requests – up to $15,000

Documentation required:

1) Completed application

2a) If applicant is **NOT** the driver: A current valid Georgia driver's license (a provisional driver's license is not acceptable)

2b) If the **applicant IS** the driver: A Current valid Georgia driver's license **renewed AFTER** the date of injury (a provisional driver's license is not acceptable)

3) If the **applicant IS** the driver: Copy of a driving evaluation **OR** a note on physician letterhead signed by a physician, stating that the applicant is able to drive

4) If the applicant is applying for a vehicle he or she must provide medical documentation that shows you have a TBI/SCI with a functional disability or a cognitive disability

Note:
Modified vehicle include vans, pickup truck or SUV **ONLY**

The Commission will not consider replacement of operable vehicles.

If you have already been awarded a vehicle of any type by the Brain & Spinal Injury Trust Fund Commission you are NOT eligible to apply for another one.

The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible to the applicant.

Before you apply to the Brain & Spinal Injury Trust Fund Commission….

(FORM CL 7-01-16)

The Commission will not pay for a vehicle with a salvage title vehicle or from a member of the applicant's household. The Commission will not pay for vehicles that exceed Kelley Blue Book value.

Vehicle Quotes/invoices are NOT required during the application process but WILL be required if awarded.

❖ For vehicle modification requests, the vehicle must meet the following guidelines – up to $15,000

Documentation required:

NOTE: Modifications to a vehicle include a wheelchair lift, lowered floors, raised roof, tie-downs, hand controls or any conversion package.

1) Completed application

2) One (1) cost estimate for services: **All quotes/estimates MUST include vehicle information such as: year, make, model, and mileage. Quotes will also need to include the vendor and applicant information.**

3) The vehicle to be modified must meet the following criteria:

All vehicles **under** 8 years of age and/or under 100,000 miles will qualify for vehicle modifications.

All vehicles **equal to or over** 8 years and/or over 100,000 miles must have an ASE certified mechanic certify that the vehicle has 50,000 operable miles of use remaining. The ASE mechanic may not be employed by either the seller or modifier of the vehicle.

IMPORTANT:

THE COMMISSION CANNOT REIMBURSE APPLICANTS FOR GOODS OR SERVICES THAT YOU PURCHASED PRIOR TO YOUR RECEIPT OF AN OFFICIAL LETTER NOTIFYING YOU THAT YOUR APPLICATION REQUEST HAS BEEN APPROVED BY THE GOVERNOR'S OFFICE.

IF YOU HAVE ALREADY PURCHASED AN ITEM THAT YOU ARE REQUESTING FROM THE TRUST FUND YOUR APPLICATION OR GRANT WILL BE RESCINDED.

Brain & Spinal Injury
Trust Fund Commission

Application for Distribution

2 Peachtree St. NW, Suite 26-426, Atlanta, GA 30303
Phone 404-651-5112 • Toll Free 1-888-233-5760
Fax 404-656-9886 • email: dph-info-bsitf@dph.ga.gov

APPLICANT INFORMATION

Name of Applicant: _____

Street Address: _____

City, State, Zip (please include last 4 digits if known): _____

Mailing Address (if different from above): _____

Daytime Phone: _____ Alternate Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Last 4 digits of Social Security Number: _____ Date of Birth: _____

Name of Person Completing Application

(if different from Applicant): _____

Are you a BSITFC trained Steward? (please check one) ☐ YES ☐ NO

Name of Organization (if applicable) _____

Mailing Address: _____

City, State, Zip (please include last 4 digits if known): _____

Daytime Phone: _____ Email Address: _____

Relationship to Applicant: _____

For Commission use only: Application # _____ Region # _____

Date Entered _____ Entered by _____

Continued on next page

Ethnicity (optional, information is collected for statistical purposes only):

☐ Caucasian ☐ African American ☐ Asian/Pacific Islander ☐ Hispanic or Latino ☐ Decline to state

☐ Other:_____

How did you hear about the Trust Fund?

☐ Word of Mouth ☐ Rehabilitation Hospital ☐ Other Hospital

☐ Brain Injury Support Group ☐ Spinal Cord Injury Support Group ☐ Center for Independent Living

☐ Case Manager ☐ Brain Injury Association of Georgia (BIAG) ☐ Central Registry Letter

☐ Stewardship Program ☐ Other (please specify):_____

RESIDENCY REQUIREMENTS

Resident of Georgia? County of Residence: _____ . . . . ☐ YES ☐ NO

Have you been present in Georgia for one year or more? . . . . . ☐ YES ☐ NO

If you are employed, are you employed or engaging in any trade, profession or occupation in Georgia? . . . . . ☐ YES ☐ NO ☐ NA

Is the above street address a permanent home in Georgia to which, whenever you are absent, you intend to return? . . . . . ☐ YES ☐ NO ☐ NA

If you have school age children, have you entered your children to be educated in the private or public schools of Georgia? . . . . . ☐ YES ☐ NO

Are you a United States citizen? . . . . . ☐ YES ☐ NO

If not a U.S. citizen, are you an alien with legal authorization from the U.S. Immigration and Naturalization Service?. . . . . ☐ YES ☐ NO ☐ NA

Continued on next page

ACCESS TO OTHER RESOURCES

The Trust Fund is intended to be the funding source of last resort. Other funding sources are often available for requests such as computers, assistive technology, adaptive equipment, etc. Accessing these funding sources will maximize the Trust Fund dollars available to you. Please note that you will be required to look into all other sources of funding before your application is processed. Failure to research eligibility for these resources may result in a delay in processing your application. *You must fill out this section in its entirety*.

	Enrolled	Applied, waiting for response	Applied, not eligible	Not eligible
Personal Support Services				
Community Care Services Program (CCSP)	☐	☐	☐	☐
Independent Care Waiver Program (ICWP)	☐	☐	☐	☐
SOURCE Waiver	☐	☐	☐	☐
Mental Retardation Waiver Program (MRWP)	☐	☐	☐	☐
Other Waivers_____	☐	☐	☐	☐
Financial & Benefits Resources				
Medicaid	☐	☐	☐	☐
Medicare	☐	☐	☐	☐
Supplemental Security Income (SSI)	☐	☐	☐	☐
Social Security Disability Insurance (SSDI)	☐	☐	☐	☐
Other Resources				
Private Insurance	☐	☐	☐	☐
Short Term Disability	☐	☐	☐	☐
Long Term Disability	☐	☐	☐	☐
Vocational Rehabilitation (VR)	☐	☐	☐	☐
Veteran's Administration	☐	☐	☐	☐
Crime Victim Compensation Fund	☐	☐	☐	☐

Please provide any information about your experience with the resources list that you feel would be important for us to know. You may use a separate piece of paper.

_____

_____

_____

_____

Continued on next page

Where do you live?

☐ Own Home ☐ Rental Home ☐ Nursing Home ☐ Home of Loved One ☐ State Hospital
☐ Personal Care Home ☐ Group Home ☐ Residential Rehabilitation Center ☐ None

Describe your current living situation: _____

Who helps you in your daily life? *Check all that apply*

☐ Family in state ☐ Family out of state ☐ Friend/Neighbor ☐ Clergy/Faith Community
☐ Caseworker ☐ Support Group ☐ None ☐ Other _____

DESCRIPTION OF INJURY

Nature of Injury (Check all that apply):

☐ Traumatic Brain Injury (TBI)

☐ Spinal Cord Injury (SCI): ☐ Paraplegic ☐ Quadriplegic, What level? _____

Date of Injury: _____

Cause of Injury:

☐ Accidental fall ☐ Accidentally struck by or against an object or person ☐ Assault
☐ Self-inflicted Injury ☐ Transportation/Motor Vehicle accident ☐ Sports/Recreation
☐ Other _____

Please describe how your injury occurred:

_____

_____

_____

Please provide a letter from a physician, medical practitioner , hospital, clinic or other medical or medically related facility, or insurance company, verifying the nature and cause of your injury . Letters that do not specify the nature and cause of the injury cannot be accepted.

Continued on next page

DESCRIPTION OF REQUEST

The Trust Fund is not an entitlement and is not intended to be a permanent source of funding. Please describe the services or goods you are requesting. If you are requesting more than one service or good, please list them in order of priority, and include a quote for each request by the vendor or provider . You may attach additional information on separate paper if necessary. ***The Commission is not responsible for the quality of any good or service provided by your chosen vendor.***

1. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

Continued on next page

DESCRIPTION OF REQUEST (CONTINUED)

2. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

3. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

Continued on next page

DESCRIPTION OF REQUEST (CONTINUED)

4. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

5. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

Continued on next page

CERTIFICATION, REPRESENTATIONS, ASSURANCES AND ACKNOWLEDGEMENTS

A. By signing below, I certify to the Commission that:

1. I have read and understand the Commission's Distribution Policies (for a copy of the Policies, go to www.bsitf.state.ga.us); and
2. I have provided truthful, complete and accurate information on this application; and
3. I have exhausted all other insurance and governmental funding sources before applying to the Commission.

B. I represent and assure the Commission that, if I am granted funds, I will:

1. Use the funds for the purpose stated in this application; and
2. Promptly report in writing to the Commission any change in the availability of insurance and governmental funding sources that may affect my eligibility for funds.

C. I understand and acknowledge that:

1. The Commission has the right to rely on the information contained in this application or any subsequent amendments; and
2. The Commission has the right to withdraw or modify any disbursement in the event that:
   a. The information contained in this application or any subsequent amendment should at any time be determined to be false, incomplete, inaccurate, or misleading; or
   b. The funds are used for a purpose other than that stated in this application; or
   c. The Commission becomes aware of any change in my status or circumstances that may af fect my eligibility; and
3. The Commission's determination may affect not only continued eligibility but also af fect future eligibility for qualification; and
4. It is my responsibility to determine if the receipt of funds legally impacts other benefits that I may receive.
5. The Commission is not responsible for the quality of any good or service provided by your chosen vendors.

RELEASE/AUTHORIZATION

D. By signing below, I hereby authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to the Brain and Spinal Injury Trust Fund Commission (the "Commission") or its designee and its legal representatives:

- Any physician, medical practitioner, hospital, clinic or other medical or medical related facility , insurance company, Third Party Administrator, the Medical Information Bureau or any similar organization, institution or person, any employer, group plan holder or certificate holder .
- If the record released contains information relating to HIV test results, AIDS, alcohol abuse or mental health care, enough of this information is to be released to accomplish the purposes for which the infor - mation is requested and to the extent permitted by law .
- I understand that the information released to the Commission may be used to process my application for disbursement from the Trust Fund and may be given to any person or entity carrying out a function for , on behalf of or in conjunction with the Commission.
- This information may also be redisclosed as otherwise specifically required or permitted by law .
- This authorization shall remain in effect until revoked by me in writing.
- I may obtain a photocopy of this authorization upon request.

E. I authorize the Commission to exchange relevant information with the following person(s) in order to process the enclosed application completely and ef ficiently.

I certify that the information I have provided on this application to be true to the best of my ability . I understand that falsifying information or providing false certification(s) may be subject to civil or criminal penalties as provided by Georgia state law.

Name _____ Phone _____

Name _____ Phone _____

Signature_____ Date _____

For applications submitted by email, this Release/Authorization must, in addition, be submitted by hard copy . The Commission does not consider itself a "covered entity" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Brain & Spinal Injury Trust Fund Commission
Driver Verification Form

If you are **NOT** applying for a vehicle – **DO NOT FILL OUT THIS FORM.**

If you **ARE** requesting funding for a vehicle - Please fill out this form and submit with your application. There are several pages to complete. **Please review and fill out ALL the pages.**

BEFORE YOU BEGIN – PLEASE READ:

- The Commission will not consider replacement of operable vehicles
- The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible for the applicant

---

Applicant's Name: _____

Name of the Driver if **other** than the applicant: _____

Does this driver have a vehicle? Yes_____ No_____

Driver's Relationship to Applicant:
_____

Driver's License Number of the driver: _____

Please include with this form - a photocopy of the driver's license of the person who will be the driver of the vehicle and medical documentation that shows the applicant has a TBI/SCI with a functional disability or a cognitive disability. (Please be sure the photocopy is clear – if it is not you will be asked to re-send and it will delay the application process.)

Please answer **all** of the questions below. Unanswered questions will render the application incomplete and may delay the review process. **You may use additional pages if necessary.**

Brain & Spinal Injury Trust Fund Commission
Driver Verification Form

Applicant's Name_____

1. Does the applicant currently own a vehicle? _____**YES** _____**NO**
2. If **YES** what is the **year**_____ **make**_____ **model**_____ **mileage**_____?
3. Is there a vehicle registered in the applicant's name? _____**YES** _____**NO**
4. Why is the applicant requesting funding for another vehicle?
5. Are there other vehicles in the home? _____**YES** _____**NO**
6. If **YES** – does the applicant have access to those vehicles? **(please explain)**
7. If awarded – Will the requested vehicle be used for the direct, sole benefit of the applicant?

   _____**YES** _____**NO (please explain)**
8. How has the applicant been getting around since the injury?
9. Does the applicant use a _____**motorized wheelchair** ____ **manual wheelchair** _____**Both**? _____**Neither?** If both, please explain.

I understand that falsifying information or providing false certification(s) may be subject to civil or criminal penalties as provided by Georgia state law or disqualification from applying to the BSITFC.

Brain & Spinal Injury Trust Fund Commission
Driver Verification Form

Signature of the Applicant _____ Date _____

Signature of Driver _____ Date _____
(if different from applicant)

NOTE: Recipients of distributions are responsible for **any and all taxes**, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

- **Vehicle (non-modified) requests – up to $10,000**

Documentation required:

For non-modified vehicles and non-modified vans

1) Completed application

2a) If applicant is **NOT** the driver: A current valid Georgia driver's license (a provisional driver's license is not acceptable)

2b) If the applicant **IS** the driver: A current valid Georgia driver's license **renewed AFTER** the date of injury (a provisional driver's license is not acceptable)

3) Copy of a driving evaluation **OR** a note on physician letterhead signed by a physician, stating that the applicant is able to drive

4) Medical documentation that shows the applicant has a TBI/SCI with a functional disability or a cognitive disability

Note:
The Commission will not consider replacement of operable vehicles.

The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible to the applicant.

The Commission will not pay for a vehicle with a salvage title vehicle or from a member of the applicant's household.

If you have already been awarded a vehicle of any type by the Brain & Spinal Injury Trust Fund Commission you are NOT eligible to apply for another one.

Quotes/invoices are NOT required during the application process but WILL be required if you are awarded.

Commission staff will contact applicant about **specific** requirements and additional documentation for home modification requests. Requests for home modifications CANNOT increase the square footage of the home.

- **Modified Vehicle requests – up to $15,000**

Documentation required:

1) Completed application

2a) If applicant is **NOT** the driver: A current valid Georgia driver's license (a provisional driver's license is not acceptable)

2b) If the applicant **IS** the driver: A Current valid Georgia driver's license **renewed AFTER** the date of injury (a provisional driver's license is not acceptable)

3) Copy of a driving evaluation **OR** a note on physician letterhead signed by a physician, stating that the applicant is able to drive

4) Medical documentation that shows the applicant has a TBI/SCI with a functional disability or a cognitive disability

Note:
The Commission will not consider replacement of operable vehicles.

The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible to the applicant.

The Commission will not pay for a vehicle with a salvage title vehicle or from a member of the applicant's household.

If you have already been awarded a vehicle of any type by the Brain & Spinal Injury Trust Fund Commission you are NOT eligible to apply for another one.

Quotes/invoices are NOT required during the application process but WILL be required if you are awarded.

- **For vehicle modification requests, the vehicle must meet the following guidelines – up to $15,000**

Documentation required:

NOTE: Modifications to a vehicle include a wheelchair lift, lowered floors, raised roof, or any conversion package.

1) Completed application

2) One (1) cost estimate for services: **All quotes/estimates MUST include vehicle information such as: year, make, model, and mileage. Quotes will also need to include the vendor and applicant information.**

3) The vehicle to be modified must meet the following criteria:

Full-sized van must be a model year 5 years or less than the current model year at the time of the application and have no more than 50,000 actual miles

Mini van must be a model year 3 years or less than the current model year at the time of application and no more than 36,000 actual miles

Other vehicles must be a model year 10 years or less than the current model year at the time of application

NOTE: If vehicle does not meet the above requirements, applicant must submit an ASE certification that the vehicle has at least 50,000 operable miles remaining. The certifying mechanic must not be associated with the vendor that will be modifying or selling the vehicle.

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

Name_____

Social Security # **(LAST 4 DIGITS ONLY)** _____

Injury Type (circle one): SCI (What Level? _____) / TBI / SCI & TBI

==========

Please complete each section of the Daily Living Survey and return to the Commission office. The address is on the last page. This survey provides information to the Commission to help process your application.

Instructions:

- Please do not leave **ANY** questions blank.
- Only answer the questions with an X or a check mark ✓.
- Please DO NOT answer with words such as YES, NO, N/A or any others unless the question asks for a written answer
- Only provide 1 (ONE) answer per question unless otherwise instructed.
- Do not add or write additional explanations about your answers. If you have additional information you would like to add – please write it out and send on a separate piece of paper with your application

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

<u>HOUSING</u> (provide only ONE answer for each question)

1. **Where do you live?**

   a) _____ I own or rent my home or apartment.

   b) _____ I live with family, a loved one, or a friend who covers my housing expenses.

   c) _____I have a temporary living situation and am seeking more stable housing.

   d) _____I have serious circumstances that put me at risk for losing my home or apartment.

   e) _____ I live in a nursing home, group home or other care facility.

   f) _____ I am homeless.

2. **Do you have home modifications that allow you to live independently?**

   a) _____I do not need home modifications.

   b) _____I have home modifications and require them to remain in my own home.

   c) _____I have modifications but due to changes in my circumstances I need additional modifications.

   d) _____I do not have home modifications and I need them in order to remain in my own home.

3. **Are you at risk of being placed in an institution such as a hospital, nursing home, prison or state hospital?**

   a) _____I have never been in an institution and am not at risk.

   b) ____ I have been in an institution before (more than one year ago), but am no longer at risk.

   c) _____I have been in an institution recently (in the past year) but am currently living at home.

   d) _____I have serious circumstances that put me at risk of being institutionalized.

   e) _____I am currently in an institution.

TRANSPORTATION

4. Are you able to drive yourself?

(ONLY CHOOSE ONE ANSWER – unless your answer has multiple choices listed)

a) _____**Yes**. I drive independently and without any assistance or adaptations to my vehicle. **(skip to question 7)**

b) _____**Yes**. I drive independently with some assistance or adaptation to my vehicle. **(skip to question 7)**

c) _____ **No**. I am unsure if I can drive or not. **(Go to questions 5 & 6)**

d) _____ **No**. Someone has to drive for me. **(Go to questions 5 & 6)**

e) _____ **No**. I do not have any access to driving because **(Please choose ONE. Then go to questions 5 & 6):**

e1._____I don't have a vehicle.

e2._____My vehicle needs to be modified to accommodate my injury.

e3._____I need a driver's evaluation and/or training.

e4._____I don't have a valid driver's license.

e5._____My injury prevents me from being able to drive.

e6._____I am too young to drive.

e7._____I don't want to drive.

5. **If you answered <u>"NO" to question 4</u>, do you have someone who can drive you to the places you need to go?**

(ONLY CHOOSE ONE ANSWER)

a) _____Always

b) _____Often

c) _____Sometimes

d) _____Rarely

e) _____Never

6. **If you answered <u>"NO" to question 4</u>, is public transportation available to take you to most of the places you need or wish to go?**

(ONLY CHOOSE ONE ANSWER – unless your answer has multiple choices listed)

a) _____**Yes**. It is available and I am using it.

b) _____**Yes**. I use it but need assistance to use it.

c) _____**Yes**. It is available but I don't want to use public transportation.

d) _____**Yes**. Public transportation is available but not accessible for me.

(choose all that apply for d1-d2)

d1._____Public transportation is available but does not go to most of the places I need to go.
d2._____I cannot afford to use public transportation

e) _____**No**. Public transportation is not available in my community.

FAMILY / SUPPORT SYSTEM

7. What level of assistance (attendant care or cognitive support) do you need to be independent?

(ONLY CHOOSE ONE ANSWER)

a) ____ I am able to manage my affairs, pay bills, make financial decisions, and participate in my community by myself.

b) ____I may need occasional support from others who may help me to pay my bills, participate in my community, make financial decisions and/or have occasional attendant care to assist me to be independent.

c) ____I may spend part of my day independently, but have another person to provide some supervision, support, or attendant care during the day. I may need help planning my day, making appointments, taking care of daily tasks such as cooking or cleaning, making financial decisions, or accessing transportation.

d) ____I live with someone who provides supervision, support or attendant care on a regular basis. I can take part in community activities only with help from others. I need regular assistance to eat, bathe, access transportation, take medications, or make financial decisions.

e) ____ I require someone to manage my household and all finances, help me to communicate, and/or participate in community activities. I may have a guardian who makes decisions for me. People are with me on a full-time basis, able to provide direct care for me. At least one person is always present with me throughout the day and night.

FAMILY / SUPPORT SYSTEM - Continued

8. Are you getting the level of support and assistance that you need in your daily life?

(ONLY CHOOSE ONE ANSWER – unless your answer has multiple choices listed)

a) _____I do not require personal support.

b) _____I have sufficient support and assistance.
b1. – My Primary caretaker is _____

c) _____I receive assistance from parent(s)/Spouse/Children/Siblings but they are:
(choose all that apply)

c1. _____elderly
c2. _____ill

d) _____ I am in danger of losing my primary caregiver due to:
(choose all that apply for d1-d2)

d1. _____age
d2. _____illness

e) _____ No one helps me, although I do need support.

9. Did your injury affect the job(s) of anyone in your family?

(ONLY CHOOSE ONE ANSWER)

a) _____No. My family members' jobs have not been affected.

b) _____The injury did affect a family member's job but it does not have a negative impact.

c) _____Yes. One or more family members had to reduce their work hours to assist me.

d) _____Yes, one or more family members have stopped working in order to assist me and it has created some hardship.

DECISION MAKING

10. Who makes decisions for you in the following areas?

a) Personal and/or health matters (ONLY CHOOSE ONE ANSWER)

a1. _____ I make my own decisions.

a2. _____ I make my own decisions but sometimes need help from a family member, guardian, or other person.

a3 ._____ A family member, guardian, or other person makes these decisions.

b) Financial matters (ONLY CHOOSE ONE ANSWER)

b1. _____ I make my own decisions.

b2. _____ I make my own decisions but sometimes need help from a family member, guardian, or other person.

b3. _____ A family member, guardian, or other person makes these decisions.

c) Where you will live (ONLY CHOOSE ONE ANSWER)

c1. _____ I make my own decisions.

c2. _____ I make my own decisions but sometimes need help from a family member, guardian, or other person.

c3. _____ A family member, guardian, or other person makes these decisions.

COMMUNITY PARTICIPATION

(ONLY CHOOSE ONE ANSWER – unless your answer has multiple choices listed)

11. **Do you have the necessary equipment and personal support to participate in activities in your community?**

    a) _____ **Yes.** I participate in my community and do not require any equipment or support.

    b) _____ **Yes.** I participate and have equipment and/or support in order to do so.

    c) _____ I am not interested in participating in the community.

    d) _____ I participate in the community rarely because I lack equipment and/or support.

    e) ____No. I am unable to participate in community activities because:

(Choose all that apply for e1-e3)

e1._____I do not have transportation.
e2._____I do not have anyone to help me.
e3._____I do not have the necessary equipment or assistive technology.

12. **Please indicate your level of participation in the following activities in your community:**

    a) I am able to spend time with my family **(ONLY CHOOSE ONE ANSWER)**
    a1. _____Yes
    a2. _____ Not interested in spending time with my family
    a3._____No

    b) I am able to spend time with my friends **(ONLY CHOOSE ONE ANSWER)**
    b1._____Yes
    b2. _____ Not interested in spending time with my friends
    b3._____No

    c) I am able to participate in faith community activities. **(ONLY CHOOSE ONE ANSWER)**
    c1._____Yes
    c2. _____Not interested in faith community activities
    c3. _____No

    d) I am able to participate in support group activities. **(ONLY CHOOSE ONE ANSWER)**
    d1._____Yes
    d2. _____Not interested in support group activities
    d3._____No

EMPLOYMENT

13. Are you working? _____Yes (go to question 14)
_____No (skip to question 15)

14. If you answered YES to question 13 answer these questions:

a) How many hours per week do you work? _____ **(answer with a NUMBER)**

b) Do you require accommodations for your injury in order to work? **(ONLY CHOOSE ONE ANSWER)**

b1._____ I do not require any accommodations.

b2._____ I require accommodations and am able to use them successfully in order to work.

b3._____ I do not know if I need accommodations.

b4._____**Yes.** I have accommodations but they are insufficient or outdated.

b5._____**Yes.** I need accommodations but do not have them

c) Are you in danger of losing your job because you don't have accommodations?
_____Yes

_____No

15. If you answered NO to question 13 please answer the following question:
I am not working because: (ONLY CHOOSE ONE ANSWER)

a) _____ I am retired, a minor, or I choose not to work.

b) _____ I have enough support and income that I do not have to work.

c) _____ I am concerned that having a job will affect my benefits.

d) _____ I need training for a new career because my injury prevents me from doing my previous job.

e) _____ I tried but have been unable to keep a job due to my disability.

f) _____ I interview but no one will hire me due to my disability.

g) _____ I have been told by professionals that I am unable to work.

EDUCATION

16. **Regardless of your education level, are you able to read, write, and do basic math?**

_____Yes

_____Sometimes

_____No

17. If you are in elementary, middle or high school do you have the services you need?

a) _____I do not require special services in order to be in school.

b) _____I require supportive services and have what I need to be successful in school.

c) _____ I do not know if I have the services I need.

d) _____I have services but they are inadequate to help me be successful in school.

e) _____I require special services but do not have them.

f) _____I am not currently a student.

18. If you are in college do you have the services you need to complete your degree?

a) _____Yes

b) _____No, I need: (check all that apply)

_____Supportive Services

_____Financial Assistance

c) _____I am not currently a student.

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

HEALTH (PLEASE ANSWER QUESTIONS 19 - 21 WITH A NUMBER)

19. Think about your physical health which includes physical illnesses and injury. How many days in the past month was your physical health NOT good?

- Number of days _____

20. Think about your mental health which includes stress, depression and problems with emotions and behavior. How many days during the past month was your mental health NOT good?

- Number of days _____

21. How many days in the past month was your thinking or memory NOT good?

- Number of days _____

22. I am receiving enough healthcare (including counseling, therapy, and primary care)

(ONLY CHOOSE ONE ANSWER)

a) ____ Yes. I receive sufficient, quality healthcare.

b) ____ Yes. I receive healthcare but it is not always high quality.

c) _____ I do not know if I receive enough healthcare.

d) _____ I have health insurance but it does not cover what I need.

e) _____ I do not receive any healthcare and am in serious need of it.

(Please check all that apply)

e1._____I don't know where or how to get the care I need.
e2._____I don't have health insurance.

23. Which of the following medical services are you receiving? **(Please check all that apply)**

_____Counseling
_____Physical therapy
_____Occupational therapy
_____Speech therapy
_____Cognitive Therapy
_____Neuropsychological evaluation
_____Pain management
_____Urology
_____Behavior management
_____Dental
_____Vision
_____Other (explain)_____
_____None

24. Which of the following medical services do you NEED but are NOT receiving? **(please check all that apply**)

_____Counseling
_____Physical therapy
_____Occupational therapy
_____Speech therapy
_____Cognitive Therapy
_____Neuropsychological evaluation
_____Pain management
_____Urology
_____Behavior management
_____Dental
_____Vision
_____Other (explain)_____

Please return all completed pages to:

Brain & Spinal Injury Trust Fund Commission
2 Peachtree Street, NW
Suite 26-426
Atlanta, Georgia 30303
Fax 404-656-9886

For Staff Use Only:

OMTS:_____ **Date received**_____