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: Info-BSITF@dhr.state.ga.us

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______________

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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

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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.

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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:

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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.

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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: ______________________________

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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? ______________________________

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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? ______________________________

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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: ______________________________

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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? ______________________________

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

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

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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: ______________________________

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5. REQUEST: ______________________________ Amount: ____________

Provider name: ______________________________

Provider address: ______________________________

Provider phone #: ______________ Provider contact: ______________

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

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

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

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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? ______________________________

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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: ______________________________

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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 affect my eligibility; and
3. The Commission's determination may affect not only continued eligibility but also affect 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 information 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 efficiently.

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).