

Request for Proposal

Case Management & Needs Assessment Services for Applicants of The Brain and Spinal Injury Trust Fund Commission FY2010

Key Dates:

Release date: October 15, 2009

Executive Summary

- **Purpose.** The Brain and Spinal Injury Trust Fund Commission seeks traumatic brain injury case management services to understand and mitigate issues relating to the successful completion and award of Trust Fund grants to Georgians with traumatic brain injury.
- **Funds Available.** Project funding is available during Fiscal Year 2010, beginning November 7, 2009 in the amount of \$3,500. Project completion is June 30, 2010.
- **Eligible** Public/State controlled institution of Higher Education; Private Institution of Higher Education; Nonprofit with 501(c) (3) IRS status (other than Institution of Higher Education); Small Business; For-Profit Organization (Other than Small Business); State Government; U.S. Territory or Possession; Indian/Native American Tribal Government (Federally Recognized); Indian/Native American Tribal Government (Other than Federally Recognized); Indian/Native American Tribally Designated Organization; Hispanic-serving Institution; Historically Black Colleges and Universities (HBCUs); Tribally Controlled Colleges and Universities (TCCUs); Alaska Native and Native Hawaiian Serving Institutions; Regional Organization; Other(s): Eligible agencies of the Federal government; Faith-based or community based organizations
- **Eligible Contractors:** Individuals with the skills, knowledge, and resources necessary to carry out the proposed case management assessments are invited to develop an application for service delivery. Individuals from underrepresented racial and ethnic groups as well as individuals with disabilities are always encouraged to apply. Must submit a HIPAA non-disclosure form.
- **Number of Applications.** Applicants may submit one application
- **Application Materials.** A letter of application describing the organization and/or principal investigator (case manager) expertise in providing case management and needs assessment to clients with traumatic brain injury

I. Funding Opportunity Description

Background

Georgians with traumatic brain injury (TBI) or with a dual-diagnosis of TBI and spinal cord injury (SCI) are eligible to apply for grants from the Trust Fund for their care and rehabilitative needs. These grant categories include transportation, home modifications, personal support services, medical care/outpatient rehabilitation, dental services and assistive technology to name some of the most frequently chosen categories.

Persons with TBI have a history of difficulty in:

1. completing the Trust Fund application for a grant
2. choosing an appropriate category of goods and services for their grant

Due to these challenges, persons with TBI receive disproportionately less funding than persons with SCI. This proposal is intended to answer the following questions via qualitative methodologies:

1. What barriers, if any, can be identified that prevent or inhibits the applicant from submitting a complete grant application?
2. Are the goods and services chosen by the TBI applicant in their grant request appropriate to their current/future activities of daily living (ADL)/instrumental activities of daily living (IADL) as it relates to their care and rehabilitative needs?

II. Submission Dates and Times

Submissions of applications will be accepted beginning October 15, 2009. The successful applicant will be notified by November 7, 2009.

III. Funding Restrictions

All BSITFC awards are subject to the terms and conditions of this announcement. Pre-award costs are not allowable. Funding is limited to reimbursement for per diem expenses of \$150.00 per applicant and case management review/assessment/reporting per applicant not to exceed four hours @\$50.00 per hour per applicant. A total of ten applicants will comprise the scope of this pilot program for a total aggregate award of \$3,500.00.

IV. Pilot Study Project activities for service provider

The assessment of the TBI applicants (supplied by the Trust Fund) will involve the following activities:

- Initial review of the applicant file, database notes, and consultation with BSITFC staff
- Selecting a mutually agreeable date and time for an in-person interview with the applicant and their circle of support (if one exists)
- Assessment of the needs of the applicant as explained by the applicant
- Assessment of the needs of the applicant as explained by the circle of support
- Review of the applicant's application; in particular the Outcome Measurement Testing Tool (OMTT) and the actual grant request(s) with the circle of support and applicant. Does the OMTT as initially filled out adequately describe the applicants current situation.

- Assessment/Description of applicant's psychological and social situation by assessor during interview:
 - Environmental
 - Cognitive
 - Behavioral
 - Medical
 - Community Integration
 - Activities of Daily Living
 - Work (if applicable)
- What unmet needs exist regarding award category selection and application completion?
 - Use BSITFC's "awarded TBI requests" resource
 - Document any indicated barriers to application completion
- Provide written assessments for each individual receiving case management services to the BSITFC's executive director within 10 days of the assessment.
- Report on the relevancy of Trust Fund categories for the applicant for their particular situation.
- Provide assessment of the efficacy of the case manager's intervention and the Pilot Program itself, in terms of its scope, goals and objectives.

Brain and Spinal Injury Trust Fund Commission

CASE MANAGEMENT BSITF ASSESSMENT AND RECOMMENDATIONS

Recommended Criteria for Case Management Pilot Involvement:

1. Cannot complete an application
2. Cannot follow through on recommendations
3. Clear disparity in the application, i.e. patient's level of injury and requested award

The case manager will receive a packet of information from the Trust Fund of the recipient's demographics, disability and medical information and requests.

The case manager will review and set-up a meeting time that will be convenient for both parties. The meeting should include the person with TBI and a caregiver or significant other. (If person with TBI does not have one, then the meeting should still be scheduled.)

The case manager will ask questions to get information from the Daily Living Survey (see attached) and score as indicated. If this has already been completed, then verify the responses. The case manager will then complete the following template(see following pages 2 and 3 for template).

**BSITF CASE MANAGEMENT
ASSESSMENT AND
RECOMMENDATIONS**

Date:

Client's Name:

Interviewees Present:

Daily Living Score:

Summary:

List other vulnerable issues other than on the Daily Living Assessment, i.e. other factors that may prevent patient from being institutionalized.

List observations made about the:
Environment/accessibility

Psychosocial

Support systems

DME/equipment available/not available

Transportation

Financial assistance

Rehabilitation stays on services in the past (best guess of dates of services for inpatient/outpatient)

Housing, etc.

Needs and recommendations, i.e. resources BIAG, Gateway, Psychiatrist, Neurology, Neuropsychology, etc.

Conclusions:

How can trust fund help:

Prioritize with client agreed upon requests for awards:

Client's Requests _____ Case Manager Recommendations

1.

2.

3.

First Name _____ Last Name _____

Social Security # (LAST 4 DIGITS ONLY) _____

Injury Type (circle one): SCI (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.

Daily Living Survey

HOUSING

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.

Daily Living Survey

TRANSPORTATION

4. Are you able to drive yourself?

- a. _____ **Yes.** I drive independently and without any assistance or adaptations to my vehicle.
- b. _____ **Yes.** I drive independently with some assistance or adaptation to my vehicle.
- c. _____ **No.** I am unsure if I can drive or not.
- d. _____ **No.** Someone has to drive for me.
- e. _____ **No.** I do not have any access to driving because (please choose one):
 - 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 "**NO**" to question 4, do you have someone who can drive you to the places you need to go?

- a. _____ Always
- b. _____ Often
- c. _____ Sometimes
- d. _____ Rarely
- e. _____ Never

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

- 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.
 - 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.

Daily Living Survey

FAMILY/SUPPORT SYSTEM

7. What level of assistance (attendant care or cognitive support) do you need to be independent?
- 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.
8. Are you getting the level of support and assistance that you need in your daily life?
- 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:
 - c1. ____ elderly
 - c2. ____ ill
 - d. ____ I am in danger of losing my primary caregiver due to:
 - d1. ____ age
 - d2. ____ illness
 - e. ____ No one helps me, although I do need support.

Daily Living Survey

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

Daily Living Survey

COMMUNITY PARTICIPATION

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:
(check all that apply):
 - 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.
 - a1. _____ Yes
 - a2. _____ Not interested in spending time with my family
 - a3. _____ No
- b. I am able to spend time with my friends
 - b1. _____ Yes
 - b2. _____ Not interested in spending time with my friends
 - b3. _____ No
- c. I am able to participate in faith community activities
 - c1. _____ Yes
 - c2. _____ Not interested in faith community activities
 - c3. _____ No
- d. I am able to participate in support group activities
 - d1. _____ Yes
 - d2. _____ Not interested in support group activities
 - d3. _____ No

Daily Living Survey

EMPLOYMENT

13. Are you working? _____ **Yes** (go to question 14) or _____ **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? _____

b. Do you require accommodations for your injury in order to work?

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:

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.

Daily Living Survey

EDUCATION

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

- Yes
 Sometimes
 No (**skip to question 19**)

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.

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

HEALTH

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 _____

Daily Living Survey

HEALTH - continued

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

- 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.
 - 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) _____

Daily Living Survey

Please return all completed pages to:

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

For Staff Use Only:

OMTS: _____

Date received _____

Brain and Spinal Injury Trust Fund Commission
Case Management Needs Assessment for Applicants with TBI Pilot Program
October 15, 2009

Consent Form

The purpose of this program is to provide case management needs assessment to Brain and Spinal Injury Trust Fund Commission (BSITFC) applicants with a traumatic brain injury for a potential grant from the Trust Fund within the scope of this pilot program.

The applicant can give informed consent to voluntarily participate in the pilot program by signing this consent form.

The decision to not participate by declining to sign this consent form will not in any way impact any current or future grant application by the applicant to the Trust Fund. There are no consequences for not participating.

The Applicant will not incur any out-of-pocket fees for this needs assessment.

By receiving an in-home needs assessment the applicant will have a better understanding of which grant categories are appropriate for their care and rehabilitative needs.

The Case Manager and Steward will have on file at the Trust Fund signed HIPAA compliant non-disclosure forms that will protect applicant confidentiality.

The Pilot Program will match the applicant with a Trust Fund Steward who will help the applicant complete the Trust Fund application after the case manager's needs assessment is complete.

Applicants with questions before, during or after the case manager needs assessment may call the Executive Director of the Brain and Spinal Injury Trust Fund Commission at 1-888-233-5760 during regular business hours.

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Consent Agreement

I understand that by signing this consent form I authorize the Brain and Spinal Injury Trust Fund Commission to supply my application and the information contained therein with a third party Case Manager who will review my application before conducting the needs assessment with me:

I,

(name and address)

Do hereby give my consent to participate in the Brain and Spinal Injury Trust Fund Commission's Case Manager Needs Assessment Pilot Program.

I give my consent to allow the Trust Fund to share my application and all documents contained therein with the Trust Fund appointed case manager. _____ (initials)

I give my consent to allow members of my family or circle of support to be present during my in-home needs assessment with the case manager. yes no _____(initials)