

# VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

## Brain Injury Direct Services Fund Application Form

**Person Completing Application Form:** \_\_\_\_\_  
**Relationship to Person Applying for Services:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Who referred you?** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### 1. Name of Person to Receive Services \_\_\_\_\_

SSN \_\_\_\_\_ Gender \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Primary Disability \_\_\_\_\_

Date and Cause of Injury \_\_\_\_\_

Other Disability(ies) or Condition(s) \_\_\_\_\_

I understand that the information provided on this application, along with any information that is attached or included with this application, will be reviewed by the DARS Brain Injury Direct Services Fund staff for the purposes of determining eligibility for services and/or for service coordination and treatment planning. The information submitted to the Brain Injury Direct Services Fund may be shared with other DARS staff and programs, including the Vocational Rehabilitation Services Program, Woodrow Wilson Rehabilitation Center, Community Rehabilitation Case Management Services Program, and the Personal Assistance Services for People with Brain Injuries Program for the purposes of determining eligibility and/or coordinating services and planning treatment. The DARS Brain Injury Direct Services Fund may request additional information at any time to assist DARS in determining eligibility and/or coordinating services and planning treatment. Please mark one of the boxes below as appropriate and sign this form to indicate your understanding and agreement with this statement.

I affirm that I am 18 years of age or older and that I am not under a legal guardianship conferred by the court.

*Signed:* \_\_\_\_\_ *Date:* \_\_\_\_\_

I affirm that the person applying for services is less than 18 years of age **OR** is 18 years of age or older and under a legal guardianship conferred by the court. I am the legal guardian for this individual and am applying for services on his/her behalf.

*Signed:* \_\_\_\_\_ *Date:* \_\_\_\_\_

I affirm that the person applying for services is 18 years of age or older and is not under a legal guardianship conferred by the court. The individual has given me permission to submit this application to the DARS Brain Injury Direct Services Fund on his/her behalf. I have explained the above statement to the individual applying for services and he/she understands the statement to the best of his/her ability and has provided his/her consent.

*Signed:* \_\_\_\_\_ *Date:* \_\_\_\_\_

**Name of Person Applying for Services:** \_\_\_\_\_

**2. FINANCIAL**

List all source(s) and amount of financial income (e.g., disability income, insurance coverage, SSI/SSDI, legal settlement, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**3. SUPPORT**

Are there individuals in this person's living environment willing to support or participate in service recommendations (e.g., counseling sessions, minor changes to home environment, etc.)? \_\_\_\_\_

\_\_\_\_\_

**4. VOCATIONAL**

Was this person employed pre- or postinjury? If yes, describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If this person ever received DARS vocational rehabilitation services, provide approximate date(s) and name of DARS counselor and summary of services provided: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**5. MEDICAL/REHABILITATION**

Is this person medically stable (i.e., no longer receiving active medical treatment)? \_\_\_\_\_

\_\_\_\_\_

List prescription and nonprescription medications taken the by this person: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Describe medical or assistive equipment used by this person (e.g., wheelchair, adaptive utensils): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name of Person Applying for Services:** \_\_\_\_\_

List previous medical treatment/rehabilitation related to this person's injury (include dates/locations):

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Describe current medical treatment and rehabilitation related to this person's injury (e.g., physical, speech/language, occupational, or other therapy services): \_\_\_\_\_

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## **6. COGNITIVE/BEHAVIORAL/PSYCHOLOGICAL**

What level of education has this person achieved, pre and post injury? \_\_\_\_\_

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Has this person used alcohol or other drugs either pre- or post-injury? If yes, explain: \_\_\_\_\_

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\* Where and when was this person's most recent neuropsychological evaluation? \_\_\_\_\_

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\* *If available, please attach the most recent psychological and/or neuropsychological assessment information.*

What are three of this person's most important life goals? \_\_\_\_\_

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How would you rate this person's motivation to achieve these goals? \_\_\_\_\_

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What behaviors/cognitive challenges interfere with this person's ability to achieve these goals (e.g., challenging behaviors, cognitive impairments, low motivation, substance abuse)?

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What are this person's leisure interests/activities (i.e., how does he/she spend most days)? \_\_\_\_\_

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Name of Person Applying for Services: \_\_\_\_\_

## 7. REQUEST FOR PROPOSED SERVICES

Please indicate which of the following services/supports are needed to help the individual increase his/her participation in the community, enhance the ability to function independently, or to gain/maintain employment. Note that the DARS Brain Injury Direct Services (BIDS) Fund makes the final decision regarding eligibility and services to be provided, based on an assessment of needs.

Comprehensive Assessment to Determine Needs (*this would include all areas listed below*)

**OR (check all that apply)**

Assistive Technology

\_\_\_ Products (*adaptive equipment, wheelchair, computer, etc.*)

\_\_\_ Services (*assessment / training in use of adaptive equipment, computer software, etc.*)

Case Management / Service Coordination

Community Support Services (*one-to-one services designed to enhance an individual's ability to function independently in the home and community on a daily basis despite cognitive impairment, using compensatory strategies and environmental adaptations*)

Medical Rehabilitation Evaluation/Therapy

\_\_\_ Occupational Therapy Evaluation/Services

\_\_\_ Physical Therapy Evaluation/Services

\_\_\_ Speech Language Therapy Evaluation/Services

\_\_\_ Other Therapy: \_\_\_\_\_

Personal Assistance Services (*assistance with eating, dressing, bathing, etc.*)

Psychological/Neuropsychological Evaluation and/or Counseling

Vocational Rehabilitation Services

\_\_\_ Vocational Evaluation/Training

\_\_\_ Job Development/Job Site Training/Supported Employment

\_\_\_ Other: \_\_\_\_\_

**OR**

Other services/supports: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Person Applying for Services: \_\_\_\_\_

**8. LIVING SITUATION** (NOTE: This program does not pay for residential services!)

Where and with whom does this person currently live? \_\_\_\_\_

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Where and with whom will this person live during and after the time he or she receives services through this program? (NOTE: If a person wants to move from a current living situation, he or she must provide written documentation, BEFORE SERVICES BEGIN, that he/she has a place to live when services end.)

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If this person does not currently reside in an institutional setting (mental health facility, nursing home, jail), please explain how he or she might be at risk for such placement (challenging behaviors, aging caregivers, etc.): \_\_\_\_\_

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**9. ADDITIONAL COMMENTS:**

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Any additional information you would like the DARS Brain Injury Direct Services Fund to consider may be enclosed with the application. Please mail or fax the completed application form to: **Department for Aging and Rehabilitative Services, ATTN: Brain Injury Direct Services Fund, 8004 Franklin Farms Drive, Henrico, VA 23229; FAX (804) 662-7663.** Questions? Call (804) 662-7615 or e-mail [patti.goodall@dars.virginia.gov](mailto:patti.goodall@dars.virginia.gov).