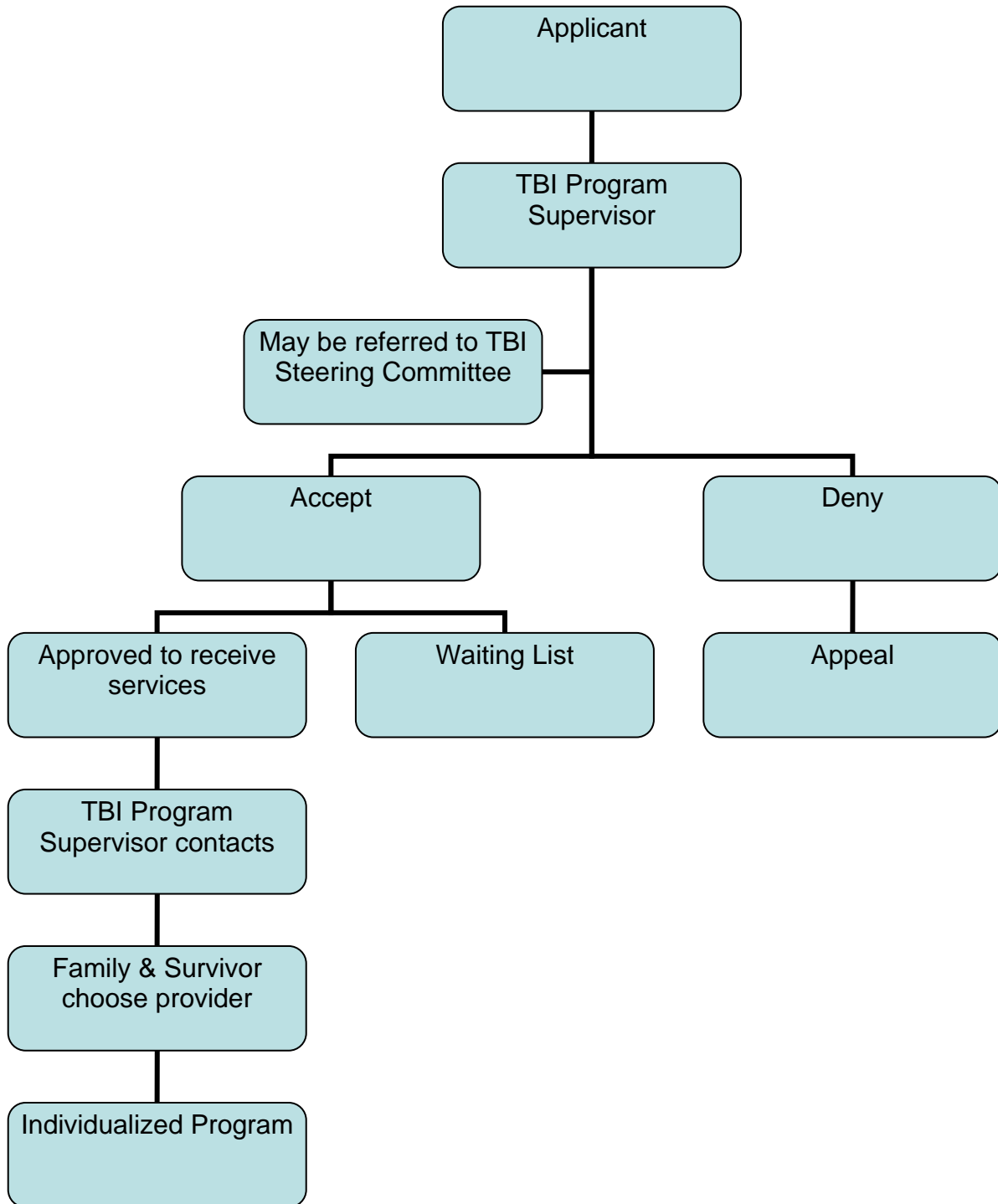


State of Vermont  
Division of Disability and Aging Services  
TBI Program

TBI PROGRAM PROCESS



**State of Vermont  
Division of Disability and Aging Services  
TBI Program**

**APPLICATION / REFERRAL / PROVIDER SELECTION PROCESS**

1. A completed, signed application is sent to the TBI Program Supervisor, Division of Disability and Aging Services, 103 South Main Street, Weeks Building, Waterbury, VT 05671-1601 by an acute rehabilitation facility, a hospital, a long-term care rehabilitation facility, an individual with a TBI, or others on behalf of the individual.
2. Upon receipt of the completed application, the TBI Program Supervisor or designee will schedule a meeting with the applicant and other relevant individuals to conduct a further assessment of eligibility for the TBI Program.
3. The applicant is then either denied or accepted to services. If the assessment is unclear, the TBI Program Supervisor, or designee, will contact the TBI Steering Committee with a recommendation for acceptance or denial. The Steering Committee will then approve or deny the applicant for services.
4. If applicant is denied services, they will be notified in writing of the decision along with instruction for the consumer's right to appeal.
5. When an individual is accepted, the TBI Program Supervisor or designee will recommend a minimum of three (3) Department of Disabilities, Aging, and Independent Living (DAIL) approved TBI Provider Agency (ies) along with the name of a contact person at the Provider Agencies in order for the consumer or guardian to discuss possible services. This recommendation will be based on the needs of the individual. The final selection of the provider agency will rest with the individual and/or their guardian.
6. The TBI Program Supervisor / designee will notify the Provider Agency of selection. A Care Plan is developed by the TBI Program Supervisor / designee; this and other necessary documentation will be sent to the provider for their review. The Provider Agency will notify the TBI Program Supervisor / designee of acceptance or denial of the TBI program consumer.
7. Once the Provider Agency accepts the consumer, the pre-admission planning process will begin.
8. If at any point during program services the consumer and/or guardian wishes to consider other Provider Agencies, the TBI Program Supervisor/designee must be notified.
9. If at any point during program services the Provider Agency is unable to meet the needs of the consumer, the TBI Program Supervisor / designee and consumer must be notified in writing. The Provider Agency will give a minimum of a 30-day notice and will assist with development and implementation of a transition plan. The State may require an extension of service provision beyond the 30 days to ensure a successful transition.

**State of Vermont  
Division of Disability and Aging Services  
TBI Program**

**APPLICATION FORM**

To:  
TBI Program  
DAIL - DDAS  
103 South Main St., Weeks Bldg.  
Waterbury, VT 05671-1601

Referred by: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
Case Manager: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Email: \_\_\_\_\_

**Applicant General Information**

**Name (Please print):** \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone (day) : (\_\_\_\_\_) \_\_\_\_\_ Phone (eve): (\_\_\_\_\_) \_\_\_\_\_

Please consider me for:  TBI Rehabilitation Program \* or  TBI Long Term Program

Male or  Female DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

\* Injury must have occurred in the last 5 years.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dietary habits: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Living situation: \_\_\_\_\_

Children (names and ages): \_\_\_\_\_

Education: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Guardian / Payee Information**

Guardian Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Revision Date: 05/01/11

Payee Name: \_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**Insurance & Income Information**

I am currently receiving:

Community Medicaid or  Long Term Medicaid or  Other: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

yes or  no Applied for Medicaid If yes, date of application \_\_\_\_/\_\_\_\_/\_\_\_\_

Income:

SSDI: \$ \_\_\_\_\_ SSI: \$ \_\_\_\_\_

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

yes or  no Applied for SSI/SSDI If yes, date of application \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medical Information**

Diagnoses: \_\_\_\_\_

Cause of Injury: \_\_\_\_\_ Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Present Location: \_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Past Medical History: \_\_\_\_\_

TBI Deficits: \_\_\_\_\_

Recent Hospitalizations/Date: \_\_\_\_\_

Long-term Rehab Facilities/Date: \_\_\_\_\_

Prior mental health issues: \_\_\_\_\_

Revision Date: 05/01/11

**Please check all services you have received or are currently receiving:**

- |  |   |
|--|---|
| <input type="checkbox"/> Developmental Services        | <input type="checkbox"/> Substance Abuse Services           |
| <input type="checkbox"/> Mental Health or CRT Services | <input type="checkbox"/> Choices for Care Services          |
| <input type="checkbox"/> Corrections/Probation         | <input type="checkbox"/> Children's Personal Care Services  |
| <input type="checkbox"/> Attendant Care Services       | <input type="checkbox"/> Neuro Resource Facilitation/BIA-VT |
| <input type="checkbox"/> Other                         |   |

**Required Documentation**

**Please attach all of the following information to this form.**

- Notice of Medicaid Eligibility
- Physician reports and letter of recommendation for community based services
- Rehabilitation facility admission and discharge summary
- Hospital admission and discharge summary, which includes documentation of a moderate to severe brain injury (e.g.; CAT Scan)
- Neuropsychological reports (if one has been done)
- Completed Independent Living Assessment Form
- Psychiatric evaluations (if applicable)
- Specialty reports or evaluations (i.e.; physical therapy, occupational therapy, speech therapy, etc.)
- Guardianship/payee papers (Required if individual has a legal guardian)

**FOR LONG-TERM APPLICANTS ONLY—INCLUDE:**

- Reports to substantiate risk factors, safety issues, and level of daily support.
- Letter(s) of denial from other applicable home and community based programs.
- Documentation of history of intensive inpatient (i.e.; other hospital admission and discharge summary), **or**
- Documentation of intensive outpatient services (i.e.; counseling, psychotherapy reports, etc.), **or**
- Physician letter to include risk of institutionalization.

\*Please note: Inadequate information or delay in providing requested information can result in denial of eligibility. Applications cannot be reviewed until all information is received.

\*\*Applicant and/or guardian should contact the appropriate State Agencies, Vermont State Police and/or Vermont Crime Information Center to resolve any outstanding legal issues, e.g.; traffic violations, warrants, etc.

**Release of Information**

- I agree to participate in the assessment of my eligibility for this program and in developing my plan of care. I understand that if I am found eligible for the TBI Program. I will be given the choice of: (1) participating in the TBI Program; (2) requesting medically necessary institutional services; (3) remaining in the community without TBI Program Services.
- I give permission to the team of persons developing my plan of care to obtain personal, medical, and financial information about me to determine my eligibility for this program. They are to keep this information confidential.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Applicant or Legal Representative(s)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Legal Representative

**State of Vermont  
Division of Disability and Aging Services  
TBI Program**

**ELIGIBILITY NOTIFICATION FORM**

**Date:** \_\_\_\_\_ **Clinical Eligibility Start Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Guardian:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Date Application Received:** \_\_\_\_\_ **Date Application Reviewed:** \_\_\_\_\_

1.  Eligible for TBI Services: \_\_\_\_\_ Program

Waiting list - you will be notified when a slot is assigned.

Slot assigned

Following is a list of provider agencies qualified to meet your needs. Please contact the Agency to discuss program services.

Choice A: \_\_\_\_\_

Choice B: \_\_\_\_\_

Choice C: \_\_\_\_\_

**NOTIFY THE TBI PROGRAM SUPERVISOR OF YOUR DECISION BY:** \_\_\_\_\_

2.  \*Not eligible - does not meet the eligibility requirement. SEE ATTACHMENT.

3.  \*Not eligible - due to inadequate information.

\_\_\_\_\_  
TBI Program Supervisor  
Division of Disability and Aging Services  
103 South Main Street, Weeks Building  
Waterbury, VT 05671-1601  
Telephone: (802) 241-1456

Date: \_\_\_\_\_

Revision Date: 05/01/11

**State of Vermont  
Division of Disability and Aging Services  
TBI Program**

**YOUR RIGHT TO APPEAL**

If your request for services from the Traumatic Brain Injury (TBI) Program is denied or services are terminated, you may proceed as follows:

To ask for more information about this decision, speak or write to the TBI Program Supervisor at the Division of Disabilities and Aging Services 103 South Main Street, Waterbury, VT 05671-1601, telephone: (802) 786-2516.

You may appeal this action. If you wish to appeal, you must do so within 90 days of the postmark date of this decision. To appeal, write to the Commissioner's Office, 103 South Main Street, Waterbury, VT 05671-1601 or call 802-871-3345. You may also call toll-free at 1-800-252-8427 and ask to be transferred to the TBI Program.

You may also request a fair hearing from the Human Services Board by writing the Human Services Board, 14-16 Baldwin Street, 2<sup>nd</sup> Floor, Montpelier, VT 05633-4302. If you wish to request a fair Hearing, you must write to the Human Services Board within 90 days of the postmark date of the decision or within 30 days of the Commissioner's review.

**This information is important. If you do not understand it, take it to your local office for help.**

Ces informations sont importantes. Si vous ne les comprenez pas, apportez-les à votre bureau local pour recevoir de l'aide. **French**

Это важная информация. Если она Вам непонятна, возьмите это письмо и обратитесь за помощью в местное отделение. **Russian**

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć. **Serbo-Croatian**

Esta información es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda. **Spanish**

Maelezo ya barua hii ni muhimu. Kama huielewi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi. **Swahili**

Thông tin này rất quan trọng. Nếu quý vị không hiểu nội dung trong này, hãy đem thư này đến văn phòng tại địa phương của quý vị và nhờ nhân viên giúp đỡ. **Vietnamese**

**State of Vermont  
Division of Disability and Aging Services  
TBI Program**

**SUGGESTED SAMPLE QUESTIONS FOR PROVIDER SELECTION**

PROVIDER AGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

AGENCY REPRESENTATIVE \_\_\_\_\_ DATE \_\_\_\_\_

1. Where is your agency located?
  
  
  
  
  
  
  
  
  
  
2. How long has your agency been in operation?
  
  
  
  
  
  
  
  
  
  
3. What type of services do you provide?
  
  
  
  
  
  
  
  
  
  
4. What do you feel are your agency strengths and challenges?
  
  
  
  
  
  
  
  
  
  
5. What is your agency's philosophy on rehabilitation?
  
  
  
  
  
  
  
  
  
  
6. How long have you been associated with the TBI Program?
  
  
  
  
  
  
  
  
  
  
7. Have you served other individuals with TBI?
  
  
  
  
  
  
  
  
  
  
8. What is your experience and training in working with TBI?



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9. What services would be available for the client?

10. How would they get their therapy requirements met?

11. Who would be the Case Manager and other individuals working with the client? Would these people be available to meet with client/guardian?

12. Do the individuals identified to work with the client have experience in working with TBI clients?

13. What if the client and the Case Manager/Life Skills Aides do not get along?

14. What might a daily schedule look like?

15. What if the client wants to return to work?

**OTHER QUESTIONS:**