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Brain Injury Program – Application Package

The application package can be completed by: the applicant, a family member, physician, community professional (e.g. occupational therapist), hospital social worker, advocate or other rehabilitation professionals. The application package must be signed by the applicant or legal representative.

Please submit the completed application package to:

By Mail:
Brain Injury Program
307A – 1450 Hillside Avenue
Victoria, BC V8T 2B7

Or
By Fax:
(250)519-5258

Applications will not be processed unless all required information and documentation is included.

Checklist for required information and documents:
( ) Application form
( ) Medical documentation of Acquired Brain Injury: CT Scan, Neurologist report, Physiatrist report or MRI report
( ) Consent form (signed and witnessed)
( ) Medical, rehabilitation (OT- occupational therapist, PT - physiotherapist, SLP – speech and language pathologist, etc.) or hospital discharge reports if available

If you need help with this application, please call the Program at (250)519-5299

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The Ministry of Health has adopted the World Health Organization definition of Acquired Brain Injury:

> *Damage to the brain, which occurs after birth and is not related to a congenital or degenerative disease. These impairments may be temporary or permanent and cause partial or functional disability or psychological maladjustment (Geneva 1996)*

Based on this definition, to be eligible for service an Applicant must have sustained a brain injury that has functional impact. This could include traumatic injuries such as falls or assaults and organic injuries such as strokes or aneurysms. It does **not** include degenerative or progressive diseases (such as Multiple Sclerosis or Huntington's disease) or congenital disorders (Down syndrome or Cerebral Palsy).

General Eligibility Criteria

In order to qualify for admission to the Brain Injury Program (BIP), all applicants must meet the eligibility requirements:

1. 19 years and older
2. Diagnosis or medical evidence of an acquired brain injury (e.g. CT scan, MRI report, neurological or physiatrist's report)
3. Live within the boundaries of Island Health and meet residency as defined by Home and Community Care
4. No (or limited) funding or access to services from other sources such as – ICBC, WorkSafe, Crime Victims Assistance Program, or Veteran's Affairs, etc.)

In addition to the above general criteria, certain programs within the Brain Injury Program have additional eligibility requirements.

Admission Criteria

1. Applicant must consent to receive services and actively participate to the best of their ability.
2. Complete Application Package with required documents and reports submitted.
3. Potential to benefit from services (as determined by the Brain Injury Program).

Exclusionary Criteria

There are no specific exclusionary criteria, however all applications and supporting documentation will be reviewed to determine if there are circumstances that could prevent full participation in BIP services at the time of application (e.g. impending incarceration, substance use, or no (or limited) insight to injury impact.

For questions regarding eligibility, please call the Brain Injury Program at 250-519-5299 before completing and submitting this application. After submitting the application package, please notify the program of any changes to the information provided in your application package (address, contact information, new injury, etc.)

All services are subject to program resource availability.

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BIP Application Part A: APPLICANT INFORMATION

Last Name:	**First Name:**	**Initial:**

BC Services Card Number (Personal Health No)**:**	**Date of Birth:** (MM/DD/YY)	**Age:**

Gender: **Male** ☐ **Female** ☐	**Marital Status:** **Single** ☐ **Common-law** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widow** ☐

Home Address: How long has the applicant resided at this address:

City:	**Province:**	**Postal Code:**

Phone Number:	**Cell Number:**	**Email:**

Current location (if different than above):

Who should we contact regarding this application: **Applicant** ☐ **Other** ☐ **Or Both** ☐
If **Other** or **Both** please fill in the section below.

Name:	**Relationship to the Applicant:**

Phone Number:	**Cell Number:**	**Email:**

Family Physician: (name and phone number) Is the applicant's family Physician aware of this application for service: yes ☐ no ☐

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BIP Application Part B: INJURY INFORMATION

Date of Brain Injury: (MM/DD/YY)

Type/Cause of Brain Injury: (check the one applicable to this application)

CVA - stroke		**MVA**		**Assault**		**Fall**	
Disease		**Infection**		**Tumor**		**Anoxia**	
Drug Overdose		**Sports related**		**Work related**		**Toxic exposure**	
Self-harm		**Unknown***		**Other***			
***Please explain:**							

Is the applicant currently in hospital: yes ☐ no ☐	**Discharge Date:**

Confirmation of an Acquired Brain Injury:

Please indicate which of the following has been included with this application as evidence of a brain injury:

CT Scan Report ☐ Neurology Report ☐ MRI Report ☐ Physiatrist Report ☐

If an Applicant/Family member is completing this application, please contact our program (250-519-5299) to discuss how to confirm a Brain Injury.

Medical, Rehabilitation and Discharge reports:

Please indicate if any of these reports are included as attachments with this application:

Occupational Therapy Report ☐ Physiotherapy Report ☐ Physician or Specialist Report ☐
Speech Language Pathology Report ☐ Hospital or Rehabilitation Discharge Report ☐
Mental Health Substance Use Report ☐ RAI – Residential Assessment Instrument ☐

If above reports are available or soon to be available, but not included with this application, please state the reason and anticipated date of delivery to the BIP:

Please be aware application may not be processed if a clinical report is needed to determine **eligibility** or **service need**. It is the responsibility of the referring person or agency to provide this information.

Is the Applicant's injury the result of any of the following:	**Yes***	**No**
Work related accident		
Motor vehicle accident		
Victim of a crime (assault)		
*If **yes**, please provide application status, file number, contact information for involved agency:		

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BIP Application Part C: PRESENTING PROBLEMS AND SYMPTOMS

How has this brain injury impacted the applicant? Please check all that apply.							
Orientation		**Physical**		**Impulsive**		**Communication**	
Memory		**Pain**		**Irritability**		**Aggression**	
Attention		**Mobility**		**Gets lost easily**		**Sadness**	
Initiation		**Fatigue**		**Insight**		**Nervousness**	
Organization		**Sensory issues**		**Motivation**		**Self-harm**	
Multitasking		**Seizures**		**Judgment**		**Isolation**	
Gets confused		**Other medical**		**Fixated thoughts** (perseveration)			

Activities of Daily Living and Instrumental Activities of Daily Living (mark level of care needed)						
Personal care	Independent		Cueing or assistance		Total care	
Medication management	Independent		Cueing or assistance		Total care	
Attending appointments	Independent		Cueing or assistance		Total care	
Household Management	Independent		Cueing or assistance		Total care	
Grocery shopping, cooking	Independent		Cueing or assistance		Total care	
Financial management	Independent		Cueing or assistance		Total care	
Transportation	Independent		Cueing or assistance		Total care	
Comments:						

Can the applicant use the phone?	**Yes**		**No**		**Unsure**	
Can the applicant be left alone?	**Yes** (for how long)		**No**		**Unsure**	

Other Medical Issues or Diagnoses? Please check all that apply.

Mental Illness		**Seizures**		**Developmental Disability**		**Wernicke's Korsakoff**	
Anxiety		**Diabetes**		**Fetal Alcohol SD**		**Dementia**	
Depression		**Chronic Pain**		**Autism SD**			

Please specify condition(s), current status, and treating physician or service:

Does the applicant have any allergies? **Yes** ☐ **No** ☐ If Yes, please specify:

Is the applicant on any medication? **Yes** ☐ **No** ☐ If Yes, please specify:

Does the applicant have a current or recent substance use problem? **Yes** ☐ **No** ☐

If **Yes**, please explain – include detox, recovery programs, ACT team, SORT, etc. involvement:

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BIP Application Part D: HOUSING, EMPLOYMENT, LEGAL and INCOME INFORMATION

Current Housing:

Own House/Condo		**Shelter**		**Family Care Home**		**Care Facility**	
Rent House/Apartment		**Homeless**		**Group Home**		**Other***	
*Please describe:							

Current Living Arrangements:

Lives alone		**Roommate(s)**		**Spouse/Partner**		**Spouse and children**	
Children only				**Parents/Guardians**			

Current Employment Status:

Employed*		**Unemployed**		**Self employed**		**Retired**	
On Disability		**Medical leave**		**Volunteer**		**At home parent**	
*List Occupation							

Legal Information:

Does the Applicant have any of the following:	**Yes***	**No**
Power of Attorney (has given to someone else)		
Representation Agreement		
Committee of Person		
Public Guardian and Trustee Involvement		
Does the Applicant have any criminal history		
*if **yes**, please provide type of agreement, name and contact information:		

Income Information: (Mark all that apply)

Employment Income		**Short Term Disability**		**Employment Insurance**	
Long Term Disability		**Work Pension Plan**		**Private Insurance**	
Canada Pension Plan CPP		**CPP Disability**		**Annuity**	
Income Assistance PWD		**General Assistance**		**Work Safe BC WCB**	
ICBC		**Criminal Injury Compensation CVAP**			
If the applicant will need **Income Assistance** – has a **Person With Disability PWD application** been completed and submitted to the **Ministry Social of Development?** **Yes** ☐ ***No** ☐ *If **no,** indicate why this has not occurred:					

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BIP Application Part E: SERVICE INFORMATION

Please identify the services being requested by the applicant (mark all that apply):

Community Services	**Transitional Supports**		**Counselling**	
	Outreach Supports		**Day Program**	
Community Residential Services	**Group Living** 24 hour access to support and supervision		**Transitional Supported Apartment**	
	Family Care Home		**Transitional Family Care Home**	
For descriptions of all BIP community and residential services please refer to http://www.viha.ca/hcc/services/acquired_brain_injury_program.htm All community residential supports generally run at capacity, any questions about availability and accessibility should be directed to the BIP: 250-519-5299				

If a neuropsychiatric consult is recommended by the Brain Injury Program, can the BIP contact your family physician for a referral? Yes ☐ No ☐

Other involved Programs, Services or Specialists (mark all that apply):

Neurologist		**Out Patient Rehab**		**Brain Injury Society**	
Physiatrist		**RRAD**		**Private (OT, PT, SLP)**	
Psychiatrist		**Neuropsychiatrist**		**Neuropsychologist**	
Mental Health Substance Use		**Home and Community Care**		**Other**	
Other please describe:					

If this application is filled out by other than the applicant or applicant's family please fill in the section below:	
Referral source/name:	**Referral contact number:**

Please list and describe the applicant's support service goals:

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BIP Application Part F: CONSENT

AUTHORIZATION FOR RELEASE OF INFORMATION

INFORMATION RELEASE: The information on this form relates directly to, and is necessary for, the determination of the applicant named below to receive services from **Island Health's Brain Injury Program**. The information provided will be used to process the below named applicant's request for services. Should you have any inquiries about the collection and uses of this information, please contact the freedom of information officer. I hereby give consent to the release of any and all information regarding the below named applicant to determine eligibility for the brain injury program. I understand this information will be keep confidential.

Authorization for the Collection, Use and Disclosure of Information:

AUTHORIZATION REGARDING:_____ Print Full Name of Applicant	**DATE OF BIRTH:**_____ MM/DD/YY
I hereby permit the Island Health Brain Injury Program to collect, use and disclose personal information related to the above named applicant for the purpose of assessing eligibility, provision of services and ongoing consultation with involved professionals and agencies.	
AUTHORIZATION DATED:_____ MM/DD/YY	

By signing below I am agreeing to the above authorization

APPLICANT SIGNATURE: (or Legal Representative)	**WITNESS SIGNATURE:**
State relationship, if other than client	Witness print name
DATE:	**DATE:**

NOTE: *this authorization must be signed in original by the Applicant or Legal Representative. If authorization is given by other than the Applicant, proof of legal representation must be attached to the application package.*

The BIP requires the applicant's consent in all these areas in order to provide services.