

## **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**

<b>Last Name:</b>	<b>First Name:</b>	<b>Initial:</b>
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<b>BC Services Card Number</b> (Personal Health No):	<b>Date of Birth:</b> (MM/DD/YY)	<b>Age:</b>
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<b>Gender:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>Marital Status:</b> Single <input type="checkbox"/> Common-law <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>
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<b>Home Address:</b>
How long has the applicant resided at this address:

<b>City:</b>	<b>Province:</b>	<b>Postal Code:</b>
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<b>Phone Number:</b>	<b>Cell Number:</b>	<b>Email:</b>
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<b>Current location (if different than above):</b>
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**Who should we contact regarding this application:** Applicant  Other  Or Both   
If **Other** or **Both** please fill in the section below.

<b>Name:</b>	<b>Relationship to the Applicant:</b>
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<b>Phone Number:</b>	<b>Cell Number:</b>	<b>Email:</b>
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<b>Family Physician:</b> (name and phone number)
Is the applicant's family Physician aware of this application for service: yes <input type="checkbox"/> no <input type="checkbox"/>

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**BIP Application Part B: INJURY INFORMATION**

<b>Date of Brain Injury:</b> (MM/DD/YY)
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**Type/Cause of Brain Injury: (check the one applicable to this application)**

<b>CVA - stroke</b>	<b>MVA</b>	<b>Assault</b>	<b>Fall</b>
<b>Disease</b>	<b>Infection</b>	<b>Tumor</b>	<b>Anoxia</b>
<b>Drug Overdose</b>	<b>Sports related</b>	<b>Work related</b>	<b>Toxic exposure</b>
<b>Self-harm</b>	<b>Unknown*</b>	<b>Other*</b>	

<b>*Please explain:</b>
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<b>Is the applicant currently in hospital:</b> yes <input type="checkbox"/> no <input type="checkbox"/>	<b>Discharge Date:</b>
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**Confirmation of an Acquired Brain Injury:**

<p>Please indicate which of the following has been included with this application as evidence of a brain injury:</p> <p><b>CT Scan Report</b> <input type="checkbox"/> <b>Neurology Report</b> <input type="checkbox"/> <b>MRI Report</b> <input type="checkbox"/> <b>Physiatrist Report</b> <input type="checkbox"/></p> <p><small>If an Applicant/Family member is completing this application, please contact our program (250-519-5299) to discuss how to confirm a Brain Injury.</small></p>
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**Medical, Rehabilitation and Discharge reports:**

<p>Please indicate if any of these reports are included as attachments with this application:</p> <p><b>Occupational Therapy Report</b> <input type="checkbox"/> <b>Physiotherapy Report</b> <input type="checkbox"/> <b>Physician or Specialist Report</b> <input type="checkbox"/>  <b>Speech Language Pathology Report</b> <input type="checkbox"/> <b>Hospital or Rehabilitation Discharge Report</b> <input type="checkbox"/>  <b>Mental Health Substance Use Report</b> <input type="checkbox"/> <b>RAI – Residential Assessment Instrument</b> <input type="checkbox"/></p> <p>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:</p> <p><small>Please be aware application may not be processed if a clinical report is needed to determine <b>eligibility</b> or <b>service need</b>. It is the responsibility of the referring person or agency to provide this information.</small></p>
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<b>Is the Applicant’s injury the result of any of the following:</b>	<b>Yes*</b>	<b>No</b>
Work related accident		
Motor vehicle accident		
Victim of a crime (assault)		

<b>*If yes, please provide application status, file number, contact information for involved agency:</b>
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**BIP Application Part C: PRESENTING PROBLEMS AND SYMPTOMS**

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

<b>Activities of Daily Living and Instrumental Activities of Daily Living (mark level of care needed)</b>							
<b>Personal care</b>	Independent		Cueing or assistance		Total care		
<b>Medication management</b>	Independent		Cueing or assistance		Total care		
<b>Attending appointments</b>	Independent		Cueing or assistance		Total care		
<b>Household Management</b>	Independent		Cueing or assistance		Total care		
<b>Grocery shopping, cooking</b>	Independent		Cueing or assistance		Total care		
<b>Financial management</b>	Independent		Cueing or assistance		Total care		
<b>Transportation</b>	Independent		Cueing or assistance		Total care		
<b>Comments:</b>							
<b>Can the applicant use the phone?</b>	<b>Yes</b>		<b>No</b>		<b>Unsure</b>		
<b>Can the applicant be left alone?</b>	<b>Yes</b> (for how long)		<b>No</b>		<b>Unsure</b>		

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

<b>Mental Illness</b>		<b>Seizures</b>		<b>Developmental Disability</b>		<b>Wernicke's Korsakoff</b>	
<b>Anxiety</b>		<b>Diabetes</b>		<b>Fetal Alcohol SD</b>		<b>Dementia</b>	
<b>Depression</b>		<b>Chronic Pain</b>		<b>Autism SD</b>			

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:**

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

**Current Living Arrangements:**

<b>Lives alone</b>		<b>Roommate(s)</b>		<b>Spouse/Partner</b>		<b>Spouse and children</b>	
<b>Children only</b>			<b>Parents/Guardians</b>				

**Current Employment Status:**

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

**Legal Information:**

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

**Income Information: (Mark all that apply)**

<b>Employment Income</b>		<b>Short Term Disability</b>		<b>Employment Insurance</b>	
<b>Long Term Disability</b>		<b>Work Pension Plan</b>		<b>Private Insurance</b>	
<b>Canada Pension Plan CPP</b>		<b>CPP Disability</b>		<b>Annuity</b>	
<b>Income Assistance PWD</b>		<b>General Assistance</b>		<b>Work Safe BC WCB</b>	
<b>ICBC</b>		<b>Criminal Injury Compensation CVAP</b>			
If the applicant will need <b>Income Assistance</b> – has a <b>Person With Disability PWD application</b> been completed and submitted to the <b>Ministry Social of Development</b> ? Yes <input type="checkbox"/> *No <input type="checkbox"/>					
*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	
<p><i>For descriptions of all BIP community and residential services please refer to <a href="http://www.viha.ca/hcc/services/acquired_brain_injury_program.htm">http://www.viha.ca/hcc/services/acquired_brain_injury_program.htm</a> All community residential supports generally run at capacity, any questions about availability and accessibility should be directed to the BIP: 250-519-5299</i></p>				

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:
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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:**

<b>AUTHORIZATION REGARDING:</b> _____ <small>Print Full Name of Applicant</small>	<b>DATE OF BIRTH:</b> _____ <small>MM/DD/YY</small>
<p><b>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.</b></p>	
<b>AUTHORIZATION DATED:</b> _____ <small>MM/DD/YY</small>	

By signing below I am agreeing to the above authorization

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

**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.***