Complete this application and fax along with all items listed below to:

*Neurobehavioral Services @ **(fax)** 207-287-9229*

-or-

(mail to:)

DHHS - OADS

Attn: Neurobehavioral Services

41 Anthony Avenue, SHS #11

Augusta, Maine 04333-0011

- ☐ Brain Injury Waiver Application
- ☐ Release of Information
- ☐ Clinical Assessment and ABI Checklist
- ☐ Power of Attorney, Representative Payee, or Guardianship Documents (if applicable)
- ☐ Brain Injury Waiver Choice Letter

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Ricker Hamilton, Acting Commissioner

Department of Health and Human Services
Aging and Disability Services
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-9200; Toll Free (800) 262-2232 Fax: (207) 287-9229
TTY Users: Dial 711 (Maine Relay

Brain Injury Waiver Application

Date:_____

1. Participant Information							
Name:					DOB:		
Gender:	M F	Medicaid #:			Medicare #:		
Address:							
Town:		State:	Maine		Zip:		
Phone Number:				Marital Status:			

2. Current Residence or Facility Information *(as applicable)*							
Facility Name:							
Street Address:							
Mailing address, if different:							
City:		County:		State:	ME	Zip:	
Social Worker/Discharge Planner's Name:							
Phone #:		Fax #:					
Email address:							
Admission date: (mm/dd/yyyy):							
Current (MED Assessed) level of care:							

3. Person/Agency Making Referral *(if applicable)*						
Name of Person/Agency:						
Street Address:						
City:		County:		State:	ME	Zip:
Phone #:		Fax #:				
Email address:						

4. Legal Representative, Guardian, Power of Attorney (Provide a copy of paperwork to OADS with this application)						
Name:						
Street Address:						
City:		County:		State:	ME	Zip:
Phone #:		Alternate Phone #:				
Relationship to Client:						

5. Emergency Contact (i.e., Guardian, closest family member)							
Name:							
Street Address:							
City:		County:		State:	ME	Zip:	
Phone #:		Alternate Phone #:					
Relationship to Client:							

6. Preferred Living Arrangements			
Is assistance needed to find housing?	____Yes ____ No		
Living Preference:	Consumer's Choice	Guardian's Choice (if applicable)	Comments
With relatives/caregiver in their residence	☐	☐	
-Relative's Name: _____ Phone: _____ -Address: _____			
Alone in apartment	☐	☐	
Alone in own home	☐	☐	
In 8-bed or less group home (8 unrelated individuals)	☐	☐	
Nursing Facility	☐	☐	

7. Information about Brain Injury and Diagnosis			
Date of Injury:		Age at time of Injury:	
Description of Event that Led to Injury:			
Description of How the Injury has Impact Daily Life and Current Needs:			
Current Diagnosis:	1.		
	2.		
	3.		

8. Areas of Support Needed (check all that apply)

Part A. Risks/Challenging Behaviors/Critical Support Needs

- ❒ Lack of orientation to:
  - ❒ self
  - ❒ time
  - ❒ place
- ❒Difficulty navigating inside residence
- ❒ Disorientated outside residence
- ❒ Unsafe in the residence
- ❒ Unsafe in the kitchen
- ❒ Unsafe in the community
  - ❒Traffic/Pedestrian
- ❒ Unable to safely occupy own time
  - ❒ less than one hour
  - ❒ less than three hours
  - ❒ less than 8 hours
- ❒ Ineffective/unsafe response in emergency
- ❒ Falls
- ❒ Medication/treatment non-compliance
- ❒ Difficulty with Memory
  - ❒ Short Term Memory
  - ❒ Long Term Memory
  - ❒ Impacts Daily Tasks
- ❒ Difficulty with Expressive language
- ❒ Difficulty with Receptive language
- ❒ Unable to control eating
- ❒ Inappropriate dress
- ❒ Significant lack of motivation/initiation
- ❒ Impulsive consumption/collection
- ❒ Wanders – without clear direction of where he/she is going
- ❒ Elopes – purposely tried to leave unnoticed
- ❒ Unaware of personal boundaries
- ❒ Unaware of social cues
- ❒ Intrusive to others space
- ❒ Unable to manage interpersonal conflict
- ❒ Verbally abusive
- ❒ Taking others property
- ❒ Property destruction
- ❒ Physical assaults
- ❒ Lethal threats to self
- ❒ Lethal threats to others

Describe above checked items:

Part B. Health & ADL/IADL Support Needs		
❒ **INCONTINENCE** ❒ bladder ❒ bowel ❒ requires direct support for toileting ❒ requires cueing/monitoring for toileting	❒ **EATING** ❒ swallowing issues ❒ special diet ❒ requires direct support for eating ❒ requires cueing/monitoring	❒ **MOBILITY** ❒ uses wheelchair ❒ uses walker ❒ uses cane ❒ requires direct support for moving ❒ requires cueing/monitoring for moving
❒ **BATHING AND DRESSING** ❒ requires direct support for bathing ❒ requires cueing/monitoring for bathing ❒ requires direct support for dressing ❒ requires cueing/monitoring for dressing	❒ **SLEEP** ❒ awake at night ❒ sleeps less than 6 consecutive hours at night ❒ CPAP ❒ BIPAP	❒ **List any Specialized Nursing Care Issues** ❒ ❒ ❒ ❒ ❒ ❒ ❒
❒ **IADLs (check item if help needed with this task)** ❒ household chores ❒ money management ❒ laundry ❒ shopping ❒ cooking	Comments:	

9. Medications		
Name of Medication	Reason Prescribed	Dosing Amount and Directions

ACQUIRED BRAIN INJURY (ABI)

NEUROPSYCHOLOGIST/PHYSIATRIST CHECKLIST

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

THIS CHECKLIST IS A GUIDE TO ASSIST IN THE WRITING OF THE CLINICAL ASSESSMENT. THIS FORM MUST BE ACCOMPANIED BY A WRITTEN CLINICAL ASSESSMENT.

SUBMITTING FACILITY INFORMATION		
FACILITY NAME	CURRENT DATE	ADMISSION DATE
FAX NUMBER	PHONE NUMBER	
PRINT NAME/LICENSURE/TITLE OF PERSON COMPLETING FORM		

CONSUMER INFORMATION				
LAST NAME	**FIRST NAME**	**M.INT.**	**DATE OF BIRTH**	**MAINECARE NUMBER**

		(Circle Yes or No)	
1	THE INDIVIDUAL HAS A DIAGNOSIS OF ACQUIRED BRAIN INJURY	Y	N
2	THE INDIVIDUAL HAS RECEIVED AN ASSESSMENT BY A QUALIFIED NEUROPSYCHOLOGIST AND/OR LICENSED PHYSICIAN WHO IS BOARD CERTIFIED, OR OTHERWISE BOARD ELIGIBLE IN PHYSICAL MEDICINE AND REHABILITATION. **PLEASE ATTACH ASSESSMENT.**	Y	N
3	THE INDIVIDUAL IS NOT IN A PERSISTENT VEGETATIVE STATE	Y	N
4	THE ASSESSMENT POSITIVELY INDICATES THAT THE INDIVIDUAL IS ABLE TO DEMONSTRATE POTENTIAL FOR:		
CHECK ALL THAT APPLY	Physical Rehabilitation	Y	N
	Behavioral Rehabilitation	Y	N
	Cognitive Rehabilitation	Y	N
5	THE ASSESSMENT POSITIVELY INDICATES THAT THE INDIVIDUAL SHOWS EVIDENCE OF:		
CHECK ALL THAT APPLY	Moderate to Severe Behavioral Disability	Y	N
	Cognitive Disability	Y	N
	Functional Disability	Y	N
6	THE ASSESSMENT AT LEAST RESULTS IN SPECIFIC REHABILITATION GOALS, BASED UPON THE FINDINGS OF THE ASSESSMENT, DESCRIBING TYPES AND FREQUENCIES OF THERAPIES AND EXPECTED OUTCOMES AND TIMEFRAMES.	Y	N

ATTESTATION	
NEUROPSYCHOLOGIST/PHYSIATRIST SIGNATURE (REQUIRED):	

Aging and Disability Services
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
Aging and Disability Services
32 Blossom Lane, Marquardt Building, 2nd Floor
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-4242; Fax (207) 287-9915
TTY Users: Dial 711 (Maine Relay)

Choice Letter

Consumer:_____ Date:_____

Address:_____ MaineCare#:_____

City:_____ State:_____ Zip:_____

The brain injury waiver allows participants to choose community based services rather than residing in an institution. The goal of the waiver is to provide a comprehensive array of services to adults (age 18 and older) with an acquired brain injury. The waiver does **not** cover housing expenses, room and board, or rent.

You may be qualified for this waiver program. You can learn more about the waiver by contacting the Office of Aging and Disability Services, Neurobehavioral Services team at (207) 287-9200. You can choose to be **considered** for this waiver. The availability of waiver openings is limited.

Please check one of the following options:

☐ I WANT TO BE CONSIDERED FOR THE BRAIN INJURY WAIVER.

I understand this choice means the following:

1. I will receive help applying for the Brain Injury waiver program.
2. If I am determined eligible and granted a funded waiver offer, an Brain Injury Care Monitor will assist me in choosing the waiver services necessary to maintain my health and safety.
3. If I am determined eligible and granted a funded waiver offer, I must choose an enrolled MaineCare waiver provider to deliver those services.
4. If I am determined eligible and granted a funded waiver offer, I will take part in choosing where I want to live in the community.

☐ I DO NOT WANT TO BE CONSIDERED FOR THE BRAIN INJURY WAIVER AT THIS TIME.

I understand this choice means the following:

1. I can change my mind in the future.
2. If I have further questions, I can contact OADS at (207)287-9200.

Date:_____ _____
Participant Signature

Date:_____ _____
Guardian or Legally Authorized Representatives Signature (if applicable)

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Ricker Hamilton, Commissioner

Authorization to Release Information

We are committed to the privacy of your information. Please read this form carefully.

Which DHHS office(s) should help you? Please check.

❒Office of MaineCare Services	❒ Substance Abuse and Mental Health Services
❒Office for Family Independence and Medical Review Team	❒ Office of Child and Family Services
❒ Maine Center for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:

Whose information is being released? Please print clearly.

Individual's Name		Date of Birth	Social Security #
Home Address	Town/City	State	Zip Code
Telephone ( ) -	Email address @		

What information should DHHS release? Please check all that apply.

General permission:

❒**All** health information from the DHHS office(s) checked above
❒Claims or encounter data (information about visits to health care providers)
❒Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits
❒Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2017" or "Claims from 2015-2017")

_____

❒Other:_____

Special permission: Drug/Alcohol Referral or Services

❒Include **all** drug/alcohol information in the release
❒Include only the **specific** drug/alcohol records checked:

❒Diagnosis and treatment
❒Clinical notes and discharge summaries
❒ Drug/Alcohol history or summary
❒Payment or claims information
❒Living situation and social supports
❒Medication, dosages or supplies
❒Lab results
❒Other: _____

Special permission: Mental/Behavioral Health Services

❒Include this information in the release

❒I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.

Please note: Maine law allows us to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.

Special permission: HIV/AIDS Status/Test Results

❒Include this information in the release

Please note: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if your data is misused. **DHHS** will protect your HIV data, and all your information, as the law requires.

Are you asking DHHS to send your information by EMAIL? ❒ Yes.

Although DHHS has privacy and security protections for my information, I understand that email and the internet have risks that DHHS cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask DHHS to send my information by email. **INITIAL HERE** _____

Where should DHHS send your information by email? Please print the email address clearly:

What is the purpose of the release? Please check or write a response.

❒ **To coordinate or manage my care** ❒ **For a legal matter, including to provide testimony**
❒ **A personal request** ❒ **To see if I qualify for benefits or insurance** ❒ **Other** _____

Please check and print clearly below: ❒Send my information to ❒Get my information from:

Name	Name
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone Fax No.	Phone Fax No.

I understand and agree that:

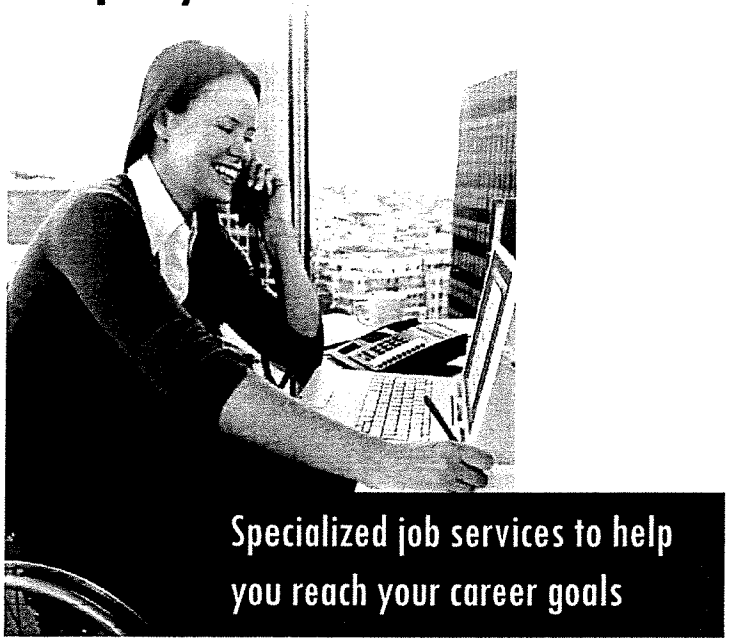
- "Information" may be in written, spoken and/or electronic format.
- This form will expire **one year** from the date below unless I revoke (take back) my permission sooner.
- To take back my permission, I will fill out the Revocation Form found at http://www.maine.gov/dhhs/privacy/index.shtml and send it to the office where I receive services. It will not apply to the information that DHHS already released with my permission.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance coverage.
- I permit the people and/or offices listed on this form to speak to each other for the purpose(s) on this form.
- Health information from other providers (such as doctors, hospitals, and counselors) in my DHHS file is included in this release.
- Unless I am applying for benefits, DHHS will not base my treatment, payment for services, or benefits on whether I sign this form.
- DHHS offices will keep my information confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, DHHS will include a notice saying that such information may not be re-released or shared without my written permission.

I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.

Date: _____ **Signature** _____

Personal Representative's authority to sign: _____

Employment Services for People with Disabilities



What Is Vocational Rehabilitation?

The Division of Vocational Rehabilitation, also known as "VR," assists individuals who have disabilities to get and keep a job. VR works with adults, as well as with eligible students to coordinate information and resources as they transition to the world of work.

To be eligible for VR Services you must:

- have a documented disability that prevents you from getting or keeping a job.
- need VR services to keep a job (Eligibility must be determined in 60 days. Medical records can usually provide the necessary documentation.)

If you are receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) based on a disability and have an interest in working, you are presumed eligible for VR services.

How Do I Apply?

To apply for VR, you need to call one of our offices and schedule an appointment with a VR counselor. The counselor will explain the program and learn more about you and your goals. You are strongly encouraged to view the online VR orientation video prior to applying for services.

www.maine.gov/rehab/videos/vr_orientation.shtml

What About My Employment Goals?

Your VR counselor will work with you to decide what jobs best fit your interests and skills. You'll also consider where you live, the current job market, and what transportation is available.

What Services Does VR Provide?

Every person's employment plan is different. VR will consider any service you need to achieve the agreed-upon vocational goal.

As you identify careers, VR can provide information about the skills and training you need. If training is necessary, VR may help with the cost of the program.

VR may buy tools, uniforms or basic equipment needed to start a job. Sometimes VR can assist with payment for some medical/psychological services. If you need a Job Coach (on-the-job support), VR will provide one. Generally services end 90 days after you start working.

How Much Will This Cost?

It does not cost you anything to apply for services. There is no charge for testing, vocational evaluation, counseling, or job placement assistance. If you are eligible for services, your counselor will ask you about your income and expenses. Depending upon your income, you may be asked to contribute to the cost of VR services. VR cannot pay for any services you received before you applied to VR, or any services not agreed upon with your counselor and written in your Individualized Plan for Employment.

Client Assistance Program (CAP), a Program of C.A.R.E.S., Inc.
CAP is an advocacy program that provides information and assistance to individuals who are applying for, or receiving VR services.
CAP exists to answer your questions, clarify the VR process, and if necessary, represent you to help resolve a problem or concern.
For more information about CAP, call:
207-377-7055 • 1-800-773-7055 • TTY users call Maine Relay 711.
C.A.R.E.S., Inc., 134 Main Street, Suite 2C, Winthrop, ME 04364

www.caresinc.org

Bureau of Rehabilitation Services
Administrative Office, 150 State House Station,
Augusta, ME 04333-0150 • 207-623-6799 • Fax 287-5292
TTY users call Maine Relay 711

MAINE DEPARTMENT OF LABOR
Division of Vocational Rehabilitation

www.maine.gov/rehab/dvr

12/16

Planning for Employment

Things to consider before starting your job search:

How much money do you need to make each month to live the life you want?

What types of work interest you?

What ways can you use to travel back and forth to work?
Some options are bike, car, walk, family/friends, co-workers, agency, bus or taxi

What towns are you able to get to?

List the help you might need to get and keep a job.

Who would give you a reference? (name and contact information)