Brain & Spinal Injury
Trust Fund Commission

Application for Distribution

Brain & Spinal Injury Trust Fund Commission
200 Piedmont Ave. SE, East Tower Suite 472
Atlanta, GA 30334
Phone 404-651-5112 •
Toll Free 1-888-233-5760
Fax 404-651-6203 • email: dph-info-bsitf@dph.ga.gov

APPLICANT INFORMATION

Name of Applicant: _____

Street Address: _____

City, State, Zip (please include last 4 digits if known): _____

Mailing Address (if different from above): _____

Daytime Phone: _____ Alternate Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Last 4 digits of Social Security Number: _____ Date of Birth: _____

Name of Person Completing Application

(if different from Applicant): _____

Are you a BSITFC trained Steward? (please check one) ☐ YES ☐ NO

Name of Organization (if applicable) _____

Mailing Address: _____

City, State, Zip (please include last 4 digits if known): _____

Daytime Phone: _____ Email Address: _____

Relationship to Applicant: _____

For Commission use only: Application # _____ Region # _____

Date Entered _____ Entered by _____

Continued on next page

Ethnicity (optional, information is collected for statistical purposes only):

☐ Caucasian ☐ African American ☐ Asian/Pacific Islander ☐ Hispanic or Latino ☐ Decline to state

☐ Other:_____

How did you hear about the Trust Fund?

☐ Word of Mouth ☐ Rehabilitation Hospital ☐ Other Hospital

☐ Brain Injury Support Group ☐ Spinal Cord Injury Support Group ☐ Center for Independent Living

☐ Case Manager ☐ Brain Injury Association of Georgia (BIAG) ☐ Central Registry Letter

☐ Stewardship Program ☐ Other (please specify):_____

RESIDENCY REQUIREMENTS

Resident of Georgia? County of Residence: _____ . . . . ☐ YES ☐ NO

Have you been present in Georgia for one year or more? . . . . . ☐ YES ☐ NO

If you are employed, are you employed or engaging in any trade, profession or occupation in Georgia? . . . . . ☐ YES ☐ NO ☐ NA

Is the above street address a permanent home in Georgia to which, whenever you are absent, you intend to return? . . . . . ☐ YES ☐ NO ☐ NA

If you have school age children, have you entered your children to be educated in the private or public schools of Georgia? . . . . . ☐ YES ☐ NO

Are you a United States citizen? . . . . . ☐ YES ☐ NO

If not a U.S. citizen, are you an alien with legal authorization from the U.S. Immigration and Naturalization Service?. . . . . ☐ YES ☐ NO ☐ NA

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ACCESS TO OTHER RESOURCES

The Trust Fund is intended to be the funding source of last resort. Other funding sources are often available for requests such as computers, assistive technology, adaptive equipment, etc. Accessing these funding sources will maximize the Trust Fund dollars available to you. Please note that you will be required to look into all other sources of funding before your application is processed. Failure to research eligibility for these resources may result in a delay in processing your application. *You must fill out this section in its entirety*.

	Enrolled	Applied, waiting for response	Applied, not eligible	Not eligible
Personal Support Services				
Community Care Services Program (CCSP)	☐	☐	☐	☐
Independent Care Waiver Program (ICWP)	☐	☐	☐	☐
SOURCE Waiver	☐	☐	☐	☐
Mental Retardation Waiver Program (MRWP)	☐	☐	☐	☐
Other Waivers_____	☐	☐	☐	☐
Financial & Benefits Resources				
Medicaid	☐	☐	☐	☐
Medicare	☐	☐	☐	☐
Supplemental Security Income (SSI)	☐	☐	☐	☐
Social Security Disability Insurance (SSDI)	☐	☐	☐	☐
Other Resources				
Private Insurance	☐	☐	☐	☐
Short Term Disability	☐	☐	☐	☐
Long Term Disability	☐	☐	☐	☐
Vocational Rehabilitation (VR)	☐	☐	☐	☐
Veteran's Administration	☐	☐	☐	☐
Crime Victim Compensation Fund	☐	☐	☐	☐

Please provide any information about your experience with the resources list that you feel would be important for us to know. You may use a separate piece of paper.

_____

_____

_____

_____

Continued on next page

Where do you live?

☐ Own Home ☐ Rental Home ☐ Nursing Home ☐ Home of Loved One ☐ State Hospital
☐ Personal Care Home ☐ Group Home ☐ Residential Rehabilitation Center ☐ None

Describe your current living situation: _____

Who helps you in your daily life? *Check all that apply*

☐ Family in state ☐ Family out of state ☐ Friend/Neighbor ☐ Clergy/Faith Community
☐ Caseworker ☐ Support Group ☐ None ☐ Other _____

DESCRIPTION OF INJURY

Nature of Injury (Check all that apply):

☐ Traumatic Brain Injury (TBI)

☐ Spinal Cord Injury (SCI): ☐ Paraplegic ☐ Quadriplegic, What level? _____

Date of Injury: _____

Cause of Injury:

☐ Accidental fall ☐ Accidentally struck by or against an object or person ☐ Assault
☐ Self-inflicted Injury ☐ Transportation/Motor Vehicle accident ☐ Sports/Recreation
☐ Other _____

Please describe how your injury occurred:

_____

_____

_____

Please provide a letter from a physician, medical practitioner , hospital, clinic or other medical or medically related facility, or insurance company, verifying the nature and cause of your injury . Letters that do not specify the nature and cause of the injury cannot be accepted.

Continued on next page

DESCRIPTION OF REQUEST

The Trust Fund is not an entitlement and is not intended to be a permanent source of funding. Please describe the services or goods you are requesting. If you are requesting more than one service or good, please list them in order of priority, and include a quote for each request by the vendor or provider . You may attach additional information on separate paper if necessary. ***The Commission is not responsible for the quality of any good or service provided by your chosen vendor.***

1. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

Continued on next page

DESCRIPTION OF REQUEST (CONTINUED)

2. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

3. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

Continued on next page

DESCRIPTION OF REQUEST (CONTINUED)

4. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

5. REQUEST: _____ Amount: _____

Provider name: _____

Provider address: _____

Provider phone #: _____ Provider contact: _____

How will this request allow you to be more independent? _____

_____

How will this request allow you to be more a part of your community? _____

_____

What will happen if you are not approved for this request? _____

_____

If the service or good you are requesting costs more than the Trust Fund provides, how will you pay for the remaining costs if you are approved for a distribution? _____

_____

If the service you are requesting is a lifetime, or long-term need, please describe your plan for being able to sustain these costs in the future: _____

_____

Continued on next page

CERTIFICATION, REPRESENTATIONS, ASSURANCES AND ACKNOWLEDGEMENTS

A. By signing below, I certify to the Commission that:

1. I have read and understand the Commission's Distribution Policies (for a copy of the Policies, go to https://bsitf.georgia.gov/how-apply/distribution-policy); and
2. I have provided truthful, complete and accurate information on this application; and
3. I have exhausted all other insurance and governmental funding sources before applying to the Commission.

B. I represent and assure the Commission that, if I am granted funds, I will:

1. Use the funds for the purpose stated in this application; and
2. Promptly report in writing to the Commission any change in the availability of insurance and governmental funding sources that may affect my eligibility for funds.

C. I understand and acknowledge that:

1. The Commission has the right to rely on the information contained in this application or any subsequent amendments; and
2. The Commission has the right to withdraw or modify any disbursement in the event that:
   a. The information contained in this application or any subsequent amendment should at any time be determined to be false, incomplete, inaccurate, or misleading; or
   b. The funds are used for a purpose other than that stated in this application; or
   c. The Commission becomes aware of any change in my status or circumstances that may af fect my eligibility; and
3. The Commission's determination may affect not only continued eligibility but also af fect future eligibility for qualification; and
4. It is my responsibility to determine if the receipt of funds legally impacts other benefits that I may receive.
5. The Commission is not responsible for the quality of any good or service provided by your chosen vendors.

RELEASE/AUTHORIZATION

D. By signing below, I hereby authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to the Brain and Spinal Injury Trust Fund Commission (the "Commission") or its designee and its legal representatives:

- Any physician, medical practitioner, hospital, clinic or other medical or medical related facility , insurance company, Third Party Administrator, the Medical Information Bureau or any similar organization, institution or person, any employer, group plan holder or certificate holder .
- If the record released contains information relating to HIV test results, AIDS, alcohol abuse or mental health care, enough of this information is to be released to accomplish the purposes for which the infor - mation is requested and to the extent permitted by law .
- I understand that the information released to the Commission may be used to process my application for disbursement from the Trust Fund and may be given to any person or entity carrying out a function for , on behalf of or in conjunction with the Commission.
- This information may also be redisclosed as otherwise specifically required or permitted by law .
- This authorization shall remain in ef fect until revoked by me in writing.
- I may obtain a photocopy of this authorization upon request.

E. I authorize the Commission to exchange relevant information with the following person(s) in order to process the enclosed application completely and ef ficiently.

I certify that the information I have provided on this application to be true to the best of my ability . I understand that falsifying information or providing false certification(s) may be subject to civil or criminal penalties as provided by Georgia state law. All decisions regarding any eligibility criteria rests solely with the BSITFC.

Name _____ Phone _____

Name _____ Phone _____

Signature _____ Date _____

For applications submitted by email, this Release/Authorization must, in addition, be submitted by hard copy . The Commission does not consider itself a "covered entity" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Brain & Spinal Injury Trust Fund Commission
Georgia Residency Requirements

Please include proof of **Georgia residency** with your completed application.

NOTE:

- All documents must show your name and your current residential address
- Applicants may cross-out account balances and/or account numbers from documents presented as proof of residency

Proof of Georgia Residency - can consist of a copy of any one of the following:

1. Non-expired Georgia driver's license, permit or identification card

2. Utility bill issued within the last sixty (60) days for services installed at your residential address (ex. water, sewer, gas, electricity, cable/satellite TV, internet, telephone/cell phone, or garbage collection)

3. Financial statement for bank/credit union account, investment account, credit card account, or loan/credit financing issued within the last sixty (60) days

4. Current, valid rental contract/agreement and/or rent payment receipts issued within the last sixty (60) days (includes rental agreement/leases for a home, apartment, mobile home, dorm, extended stay motel, retirement/assisted living home, and letter from a shelter)

5. Employer verification, including, but not limited to, one of the following:

    - Paycheck or paycheck stub
    - Letter from your employer on company letterhead
    - W-2 for current or preceding calendar year
    - Military orders

6. For minors and dependents, unexpired GA driver's license, permit, or ID card issued to parent, guardian, or spouse residing in same household; **AND** School record or transcript, report card; (if in school)

7. Health insurance statement or explanation of benefits (EOB) for claim or a health care bill/invoice

8. State of Georgia or Federal income tax return or refund check for current or preceding calendar year

9. Social Security documentation including Social Security Annual Statement for current or preceding calendar year, Numident record, or Social Security check. For more information, please go to www.ssa.gov/mystatement/

10. Statements for Federal, State, and Local assistance programs including Medicare, Medicaid, unemployment insurance claims, or WIC

11. School record or transcript, report card, student loan application, or form DS-1 for current or preceding calendar year

12. Homeowners insurance policy or premium bill for current or preceding calendar year

13. Mortgage, payment coupon, deed, escrow statement or property tax bill for current or preceding calendar year

14. Voter Registration Card

15. Auto-Insurance Policy with Applicant's name and address

16. Auto-Registration with Applicant's name and address

17. Unexpired TWIC card (Transportation Worker Identification Credential)

18. Unexpired Firearms License (Gun Permit)

19. Unexpired Merchant Marine License

20. Other Documents issued by the Federal/State/Municipal Government

21. Dept of Corrections Residency Verification Form (DS-752)

22. Georgia or Federal Income Tax Return or Refund Check for the current or preceding calendar year

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

Name_____

Social Security # **(LAST 4 DIGITS ONLY)** _____

Injury Type (circle one): SCI (What Level? _____) / TBI / SCI & TBI

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Please complete each section of the Daily Living Survey and return to the Commission office. The address is on the last page. This survey provides information to the Commission to help process your application.

Instructions:

• Please do not leave **ANY** questions blank.

• Only answer the questions with an X or a check mark ✓.

• Please DO NOT answer with words such as YES, NO, N/A or any others unless the question asks for a written answer

• Only provide 1 (ONE) answer per question unless otherwise instructed.

• Do not add or write additional explanations about your answers. If you have additional information you would like to add – please write it out and send on a separate piece of paper with your application

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

HOUSING (provide only ONE answer for each question)

1. Where do you live?

a) _____ I own or rent my home or apartment.

b) _____ I live with family, a loved one, or a friend who covers my housing expenses.

c) _____I have a temporary living situation and am seeking more stable housing.

d) _____I have serious circumstances that put me at risk for losing my home or apartment.

e) _____ I live in a nursing home, group home or other care facility.

f) _____ I am homeless.

2. Do you have home modifications that allow you to live independently?

a) _____I do not need home modifications.

b) _____I have home modifications and require them to remain in my own home.

c) _____I have modifications but due to changes in my circumstances I need additional modifications.

d) _____I do not have home modifications and I need them in order to remain in my own home.

3. Are you at risk of being placed in an institution such as a hospital, nursing home, prison or state hospital?

a) _____I have never been in an institution and am not at risk.

b) ____ I have been in an institution before (more than one year ago), but am no longer at risk.

c) _____I have been in an institution recently (in the past year) but am currently living at home.

d) _____I have serious circumstances that put me at risk of being institutionalized.

e) _____I am currently in an institution.

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

TRANSPORTATION

4. Are you able to drive yourself?

(ONLY CHOOSE ONE ANSWER – unless your answer has multiple choices listed)

a) _____**Yes**. I drive independently and without any assistance or adaptations to my vehicle. **(skip to question 7)**

b) _____**Yes**. I drive independently with some assistance or adaptation to my vehicle. **(skip to question 7)**

c) _____ **No**. I am unsure if I can drive or not. **(Go to questions 5 & 6)**

d) _____ **No**. Someone has to drive for me. **(Go to questions 5 & 6)**

e) _____ **No**. I do not have any access to driving because **(Please choose ONE. Then go to questions 5 & 6):**

e1._____I don't have a vehicle.

e2._____My vehicle needs to be modified to accommodate my injury.

e3._____I need a driver's evaluation and/or training.

e4._____I don't have a valid driver's license.

e5._____My injury prevents me from being able to drive.

e6._____I am too young to drive.

e7._____I don't want to drive.

5. If you answered <u>"NO" to question 4</u>, do you have someone who can drive you to the places you need to go?

(ONLY CHOOSE ONE ANSWER)

a) _____Always

b) _____Often

c) _____Sometimes

d) _____Rarely

e) _____Never

6. If you answered <u>"NO" to question 4</u>, is public transportation available to take you to most of the places you need or wish to go?

(ONLY CHOOSE ONE ANSWER – unless your answer has multiple choices listed)

a) _____**Yes**. It is available and I am using it.

b) _____**Yes**. I use it but need assistance to use it.

c) _____**Yes**. It is available but I don't want to use public transportation.

d) _____**Yes**. Public transportation is available but not accessible for me.

(choose all that apply for d1-d2)

d1._____Public transportation is available but does not go to most of the places I need to go.

d2._____I cannot afford to use public transportation

e) _____**No**. Public transportation is not available in my community.

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

FAMILY / SUPPORT SYSTEM

7. What level of assistance (attendant care or cognitive support) do you need to be independent?

(ONLY CHOOSE ONE ANSWER)

a) ____ I am able to manage my affairs, pay bills, make financial decisions, and participate in my community by myself.

b) ____I may need occasional support from others who may help me to pay my bills, participate in my community, make financial decisions and/or have occasional attendant care to assist me to be independent.

c) ____I may spend part of my day independently, but have another person to provide some supervision, support, or attendant care during the day. I may need help planning my day, making appointments, taking care of daily tasks such as cooking or cleaning, making financial decisions, or accessing transportation.

d) ____I live with someone who provides supervision, support or attendant care on a regular basis. I can take part in community activities only with help from others. I need regular assistance to eat, bathe, access transportation, take medications, or make financial decisions.

e) ____ I require someone to manage my household and all finances, help me to communicate, and/or participate in community activities. I may have a guardian who makes decisions for me. People are with me on a full-time basis, able to provide direct care for me. At least one person is always present with me throughout the day and night.

FAMILY / SUPPORT SYSTEM – Continued

8. Are you getting the level of support and assistance that you need in your daily life?

(ONLY CHOOSE ONE ANSWER – unless your answer has multiple choices listed)

a) _____I do not require personal support.

b) _____I have sufficient support and assistance.

b1. – My Primary caretaker is _____

c) _____I receive assistance from parent(s)/Spouse/Children/Siblings but they are:
(choose all that apply)

c1. _____elderly
c2. _____ill

d) _____ I am in danger of losing my primary caregiver due to:
(choose all that apply for d1-d2)

d1. _____age
d2. _____illness

e) _____ No one helps me, although I do need support.

9. Did your injury affect the job(s) of anyone in your family?

(ONLY CHOOSE ONE ANSWER)

a) _____No. My family members' jobs have not been affected.

b) _____The injury did affect a family member's job but it does not have a negative impact.

c) _____Yes. One or more family members had to reduce their work hours to assist me.

d) _____Yes, one or more family members have stopped working in order to assist me and it has created some hardship.

DECISION MAKING

10. Who makes decisions for you in the following areas?

a) Personal and/or health matters (ONLY CHOOSE ONE ANSWER)

a1. _____ I make my own decisions.

a2. _____ I make my own decisions but sometimes need help from a family member, guardian, or other person.

a3._____ A family member, guardian, or other person makes these decisions.

b) Financial matters (ONLY CHOOSE ONE ANSWER)

b1. _____ I make my own decisions.

b2. _____ I make my own decisions but sometimes need help from a family member, guardian, or other person.

b3. _____ A family member, guardian, or other person makes these decisions.

c) Where you will live (ONLY CHOOSE ONE ANSWER)

c1. _____ I make my own decisions.

c2. _____ I make my own decisions but sometimes need help from a family member, guardian, or other person.

c3. _____ A family member, guardian, or other person makes these decisions.

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

COMMUNITY PARTICIPATION

(ONLY CHOOSE ONE ANSWER – unless your answer has multiple choices listed)

11. Do you have the necessary equipment and personal support to participate in activities in your community?

a) _____ **Yes.** I participate in my community and do not require any equipment or support.

b) _____ **Yes.** I participate and have equipment and/or support in order to do so.

c) _____ I am not interested in participating in the community.

d) _____ I participate in the community rarely because I lack equipment and/or support.

e) ____No. I am unable to participate in community activities because:
(Choose all that apply for e1-e3)

e1._____I do not have transportation.
e2._____I do not have anyone to help me.
e3._____I do not have the necessary equipment or assistive technology.

12. Please indicate your level of participation in the following activities in your community:

a) I am able to spend time with my family **(ONLY CHOOSE ONE ANSWER)**
a1. _____Yes
a2. _____ Not interested in spending time with my family
a3._____No

b) I am able to spend time with my friends **(ONLY CHOOSE ONE ANSWER)**
b1._____Yes
b2. _____ Not interested in spending time with my friends
b3._____No

c) I am able to participate in faith community activities. **(ONLY CHOOSE ONE ANSWER)**
c1._____Yes
c2. _____Not interested in faith community activities
c3. _____No

d) I am able to participate in support group activities. **(ONLY CHOOSE ONE ANSWER)**
d1._____Yes
d2. _____Not interested in support group activities
d3._____No

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

EMPLOYMENT

13. Are you working? _____Yes (go to question 14)
_____No (skip to question 15)

14. If you answered YES to question 13 answer these questions:

a) How many hours per week do you work? _____ **(answer with a NUMBER)**

b) Do you require accommodations for your injury in order to work? **(ONLY CHOOSE ONE ANSWER)**

b1._____ I do not require any accommodations.
b2._____ I require accommodations and am able to use them successfully in order to work.
b3._____ I do not know if I need accommodations.
b4._____**Yes.** I have accommodations but they are insufficient or outdated.
b5._____**Yes.** I need accommodations but do not have them

c) Are you in danger of losing your job because you don't have accommodations?
_____Yes
_____No

15. If you answered NO to question 13 please answer the following question:
I am not working because: (ONLY CHOOSE ONE ANSWER)

a) _____ I am retired, a minor, or I choose not to work.

b) _____ I have enough support and income that I do not have to work.

c) _____ I am concerned that having a job will affect my benefits.

d) _____ I need training for a new career because my injury prevents me from doing my previous job.

e) _____ I tried but have been unable to keep a job due to my disability.

f) _____ I interview but no one will hire me due to my disability.

g) _____ I have been told by professionals that I am unable to work.

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

EDUCATION

16. **Regardless of your education level, are you able to read, write, and do basic math?**

_____Yes

_____Sometimes

_____No

17. If you are in elementary, middle or high school do you have the services you need?

a) _____I do not require special services in order to be in school.

b) _____I require supportive services and have what I need to be successful in school.

c) _____ I do not know if I have the services I need.

d) _____I have services but they are inadequate to help me be successful in school.

e) _____I require special services but do not have them.

f) _____I am not currently a student.

18. If you are in college do you have the services you need to complete your degree?

a) _____Yes

b) _____No, I need: (check all that apply)

_____Supportive Services
_____Financial Assistance

c) _____I am not currently a student.

Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

<u>HEALTH</u> (PLEASE ANSWER QUESTIONS 19 - 21 WITH A NUMBER)

19. Think about your physical health which includes physical illnesses and injury. How many days in the past month was your physical health NOT good?

- Number of days _____

20. Think about your mental health which includes stress, depression and problems with emotions and behavior. How many days during the past month was your mental health NOT good?

- Number of days _____

21. How many days in the past month was your thinking or memory NOT good?

- Number of days _____

22. I am receiving enough healthcare (including counseling, therapy, and primary care)

(ONLY CHOOSE ONE ANSWER)

a) ____ Yes. I receive sufficient, quality healthcare.

b) ____ Yes. I receive healthcare but it is not always high quality.

c) _____ I do not know if I receive enough healthcare.

d) _____ I have health insurance but it does not cover what I need.

e) _____ I do not receive any healthcare and am in serious need of it.

(Please check all that apply)

e1._____I don't know where or how to get the care I need.
e2._____I don't have health insurance.

23. Which of the following medical services are you receiving? **(Please check all that apply)**

_____Counseling
_____Physical therapy
_____Occupational therapy
_____Speech therapy
_____Cognitive Therapy
_____Neuropsychological evaluation
_____Pain management
_____Urology
_____Behavior management
_____Dental
_____Vision
_____Other (explain)_____
_____None

24. Which of the following medical services do you NEED but are NOT receiving? **(please check all that apply**)

_____Counseling
_____Physical therapy
_____Occupational therapy
_____Speech therapy
_____Cognitive Therapy
_____Neuropsychological evaluation
_____Pain management
_____Urology
_____Behavior management
_____Dental
_____Vision
_____Other (explain)_____

Please return all completed pages to:

Brain & Spinal Injury Trust Fund Commission
200 Piedmont Avenue - East Tower
Suite 472
Atlanta, Georgia 30334
eFax 404-651-6203

For Staff Use Only:

OMTS:_____ **Date received_____**

Brain & Spinal Injury Trust Fund Commission

Georgia's lead agency working to enhance the lives of Georgians with traumatic brain and spinal cord injuries.

Supporting lives of meaning, independence and inclusion.

For help completing your application or connecting to additional resources, contact us:
Phone: 404-651-5112
Toll-free: 1-888-233-5760
https://bsitf.georgia.gov
Email:
DPH-INFO-BSITF@dph.ga.gov

Since 2003, the Commission has awarded over

$25 million

in grants.

Grants support post-acute care and rehabilitation. Most frequently requested items include:

- **Transportation**
- **Personal Support Services**
- **Health and Wellness**
- **Computers**
- **Home Access Modifications**

GRANT APPLICATION PROCESS

Apply online at https://bsitf.georgia.gov

Just 3 Steps

STEP 1 **Determine Eligibility.**
You must be a U.S. citizen, a Georgia resident, and have a traumatic brain injury or spinal cord injury.

STEP 2 **Identify Your Need.**
Select an item or service that will improve your quality of life, independence, and participation in the community.

STEP 3 **Submit Required Documents.**
Complete the application and all required materials (see list below) and submit for review.

Required Documents

INJURY DOCUMENTATION
Medical documentation or letter on medical facility letterhead describing NATURE, CAUSE, and DATE of your injury.

AFFIDAVIT OF CITIZENSHIP
Present a Notary Public with a valid proof of U.S. citizenship; sign and notarize the affidavit and submit with original application.

COST QUOTE
Include one cost quote or estimate from a vendor for each request.

PROOF OF GEORGIA RESIDENCY
Submit a copy of proof of Georgia residency (e.g., valid driver's license,utility bill from past 60 days, paycheck stub, etc).

Trust Fund Awards Change Lives.

FINDING HER DESTINY: Annalyn Tocci

In the summer of 1999 Annalyn Peele, a rising 8th grader from Eastman, was riding in the car with her parents and two younger sisters going to visit friends. It was anticipated to be a great day full of fun and adventure. But in a split second, life changed right before their eyes.

A speeding gas truck approached a vehicle that was stopped ahead and, as he began to break, the truck jack-knifed in front of them. The Peele family hit the side of the truck head on.

Miraculously they all survived, but Annalyn's back was broken. She had a complete L4 spinal cord injury that left her paralyzed from the waist down. Though she had a severe concussion at the time, she was lucky to have no long-term cognitive deficit.

Annalyn's life became consumed with hospitals, doctors, nurses, and therapists. She saw first hand how those experiences and relationships could encourage or defeat a person as they struggled to recover. It was only natural for her to begin to dream of becoming a doctor that could heal people like her.

"I was meant to give back and help people."

Annalyn worked hard to strengthen her body, to become as mobile as she could be, so to accomplish her dream of going to medical school. She went from not being able to sit up, to sitting in a wheelchair, to walking with braces up to her knees, to standing with crutches. She completed her undergraduate studies at the University of Georgia majoring in Nutrition Science and Microbiology. When she was accepted into medical school in Augusta, she applied for a Trust Fund grant that would allow her to purchase a standing frame wheelchair, to enable her to more actively participate in her labs and surgical rotation. She says, "I was so excited to learn there was such a wonderful piece of equipment that could help me accomplish my goals."

Two years into medical school life threw Annalyn another curve. She met the love of her life and married. Up until then medicine had consumed her. She began to rethink her path and envision a more balanced life that would allow time for both family and medicine.

One day, while shopping at Costco, Annalyn was approached by a supervisor about working part-time in the customer service department. She got the job and soon befriended the manager in the hearing aid department. Annalyn began to learn about the tremendous need for professionals in the hearing healthcare field and found her new path. Annalyn went through a yearlong apprenticeship program via the International Hearing Society and became a Licensed Hearing Aid Dispenser.

Annalyn tells, "I loved my new job. I was able to spend time with people – to learn about their lives, to educate them, to help them overcome barriers and improve their lives with the gift of hearing. It was awesome!" Because of her journey, Annalyn could empathize first-hand with them about the tendency to be embarrassed about their disability and her patients felt her compassion for their journey.

Today, Annalyn is a wife and mother that's found a wonderful balance between her love for family and healthcare. Through it all Annalyn learned her injury didn't have to define her or limit her, but that it molded her to be what she was destined to be. She says, "My journey has opened my eyes to the fact that there are so many hurting people. I was meant to give back and help people."

Photo by Laura Brett Photography

Instructions For Completing U.S. Citizenship Affidavit
For Brain & Spinal Injury Trust Fund Commission (v12.17.2014)

Dear Applicant: **PLEASE REVIEW & TAKE THIS ENTIRE PACKET WITH YOU TO THE NOTARY PUBLIC**

Georgia law requires every applicant complete an affidavit (sworn written statement) before a Notary Public that establishes that the applicant is a citizen of the United States of America. Your application may be withdrawn or an award may be revoked if it is determined that you have provided false information. Please see the instructions listed below. **A sample affidavit is also attached.**

This packet includes:

1. Instructions for completion
2. List of Secure and Verifiable documents to present to notary
3. Sample Affidavit
4. Blank affidavit – sign and return ORIGINAL to BSITFC office

1. Review the attached list of Secure and Verifiable Documents under O.C.G.A. §50-36-2 which follows these instructions. This list contains a number of identification sources to choose from that are considered secure and verifiable that you can use to establish your U.S. citizenship, such as a birth certificate or a U.S. passport. **NOTE – a driver's license or state ID cannot serve as proof of U.S. citizenship.** Locate **one** original document on the list to bring to the Notary Public to establish your identity.

2. Fill in the blanks on the attached Affidavit, above the signature line only—**BUT DO NOT SIGN** THE AFFIDAVIT at this time. (You will sign the affidavit in the presence front of the Notary Public.) **Fill in the name of the secure and verifiable document** (for example, birth certificate or U.S. passport) that you presented to the Notary Public as proof of U.S. citizenship. **NOTE**: Only U.S. citizens may apply for a BSITFC grant. If you are not a U.S. citizen, you are not eligible to apply.

3. Bring your affidavit and the identification you selected (**from the attached list of Secure and Verifiable Documents)** to appear before the Notary Public. (Public libraries and banks often have a Notary Public). **NOTE – a driver's license or state ID cannot serve as proof of U.S. citizenship.**

4. Show the Notary Public your secure and verifiable identification and state under oath in the presence of the Notary Public that you are who you say you are and that you are a United States citizen. **Then** sign your name. **NOTE – a driver's license or state ID cannot serve as proof of U.S. citizenship.**

5. Make certain the Notary Public signs and dates the affidavit and writes the date the notary commission expires. **PLEASE MAKE SURE YOU HAVE FILLED IN THE NAME OF THE SECURE AND VERIFIABLE DOUCMENT YOU SHOWED THE NOTARY PUBLIC.**

6. Make a copy of the affidavit and the identification that you presented to the Notary Public for your own records.

7. Send the **ORIGINAL SIGNED AFFIDAVIT** document you presented to the Notary Public with your BSITFC application. **You may mail to the address below.**

Brain & Spinal Injury Trust Fund Commission www.bsitf.georgia.gov
***200* Piedmont Ave. SE, EAST TOWER Suite 472 Atlanta, Ga 30303**
888/233-5760 – Toll Free 404/651-5112 Phone 404-651-6203 eFax

Affidavit of Citizenship
Brain & Spinal Injury Trust Fund Commission

SAMPLE ONLY – PLEASE DO NOT FILL OUT **SAMPLE ONLY – PLEASE DO NOT FILL OUT**

O.C.G. A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for a(n) _____grant_____ [*type of public benefit*], as referenced in O.C.G.A. § 50-36-1, from _the Brain & Spinal Injury Trust Fund Commission [*name of government entity*], the undersigned applicant verifies one of the following with respect to my application for a public benefit:

Please check ONE of the boxes below

1)_____ I am a United States Citizen.
2)_____ I am a legal permanent resident of the United States.
3)_____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is:_____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G. A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:

_____**FILL OUT THIS LINE**_____.

[Must be filled out the line above- See attached list for acceptable documents]

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____(city), _____(state).

Notary should complete this line.

_____
Signature of Applicant

_____
Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
____DAY OF _____, 20__

Notary should complete this section and sign and seal

_____
NOTARY PUBLIC
My Commission Expires:

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued February 20, 2018, by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA"), as amended by Senate Bill 160, signed into law as Act No. 27, (2013), provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(g). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- An unexpired United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An unexpired United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An unexpired driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2][1]

- An unexpired identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

[1] For identification presented to poll workers when voting, a registered Georgia voter may present an expired Georgia driver's license as proof of identification when voting pursuant to O.C.G.A. § 21-2-417.

- An unexpired tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be accessed at: https://www.bia.gov/tribal-leaders-directory [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An unexpired United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An unexpired Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An unexpired passport issued by a foreign government, provided that such passport is accompanied by a United States Department of Homeland Security ("DHS") Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual's lawful immigration status or other proof of lawful presence under federal immigration law[2] [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An unexpired Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An unexpired Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- An unexpired NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- An unexpired Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- An unexpired driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

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[2] Senate Bill 160 (Act No. 27), effective July 1, 2013, limited the use of passports issued by foreign nations to satisfy the requirements for submission of secure and verifiable documents to only those passports submitted in conjunction with a United States Department of Homeland Security ("DHS") Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual's lawful immigration status or other proof of lawful presence under federal immigration law.

- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Certification of Report of Birth issued by the United States Department of State (Form DS-1350) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- When applying for any public benefit with the Department of Driver Services, an applicant may submit either an expired or unexpired document that is listed above as a secure and verifiable document. [O.C.G.A. §§ 50-36-1(g) & 50-36-2(b)(3)]

- When applying for a voter identification card pursuant to O.C.G.A. § 21-2-417.1, an individual may submit the aggregate forms of identification authorized by O.C.G.A. § 21-2-417.1(e).

- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

Affidavit of Citizenship
Brain & Spinal Injury Trust Fund Commission

O.C.G. A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for a(n) _____grant_____ [*type of public benefit*], as referenced in O.C.G.A. § 50-36-1, from _the Brain & Spinal Injury Trust Fund Commission [*name of government entity*], the undersigned applicant verifies one of the following with respect to my application for a public benefit:

1)_____ I am a United States Citizen.

2)_____ I am a legal permanent resident of the United States.

3)_____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is:_____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G. A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:

_____.

[*Must be filled out- See attached list for acceptable documents*]

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____(city), _____(state).

_____
Signature of Applicant

_____
Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
____DAY OF _____, 20__

_____
NOTARY PUBLIC
My Commission Expires: