Individuals who sustain a traumatic brain or spinal cord injury from external physical forces. Which include but not limited to:
- Motor vehicle accident
- Assault
- Gun shot
- Falls
- Sport injuries
- Shaken baby syndrome.

A completed application
- Signature page
- Medical documentation from a medical doctor, medical facility or hospital (psychologist and chiropractors are not accepted) stating how, when, and the date of your injury.
- Proof of GA residency (see attached form for a list acceptable documents)
- Proof of Citizenship (affidavit and instructions are enclosed)

PLEASE READ THE ENCLOSED CHECKLIST FOR FURTHER INFORMATION!

Non-eligible injuries includes but not limited to:
- Cerebral palsy
- Stroke
- Developmental disabilities
- Birth-related disorders
- Depression
- Spinal bifida
- Systic fibrosis
- Surgery related incidents
  - Anoxia (loss of oxygen)

The Brain and Spinal Injury Trust Fund Commission has set the TOTAL MAXIMUM of $10,000 per eligible applicant. Maximum amount per category is in the attached checklist.

- Any type of housing
- Vehicle repairs
- Internet service
- Legal expenses
- Taxes or tax penalties
- Medications
- Medical insurance premiums
- Moving expenses
- Vacation or airfare
- Furniture/appliances

(exceptions for front loading washers & dryers, accessible stoves/ovens and physician prescribed hospital bed)
To applicants of the Brain and Spinal Injury Trust Fund Commission,

Thank you for your interest in applying for an award. Your packet contains:

- **Checklist Packet** - contains everything you need to know to begin this process. (amounts you can request, documentation needed, and MORE)

- **Application Packet** - Please fill out the entire application completely. Incomplete pages will delay the process.

If you have questions about how to fill out the application, please call the Commission office at 404-651-5112 and ask to speak to an application assistant. Thank you for allowing us to support you in your endeavors to be independent and successful. When you are ready to submit your application please send to:

Brain & Spinal Injury Trust Fund Commission
2 Peachtree St. NW, Suite 26-416
Atlanta GA 30303
Phone: 404-651-5112 or 1-888-233-5760
Fax: 404-656-9886
dph-info-bsitf@dph.ga.gov

**NOTE:**

- There is a $10,000 distribution cap unless you are applying for modified van, modified pickup truck, or modified SUV (See policies for new changes). If you are a returning applicant and have been previously awarded $10,000 or more, you are no longer eligible to apply.

- There is a $15,000 distribution cap ONLY for a modified van, modified pickup truck, or modified SUV.

- Keep this packet for reference throughout the application process.

Be sure to make a copy of your application and supporting documents to keep for your records.
BEFORE YOU APPLY TO THE BRAIN & SPINAL INJURY TRUST FUND COMMISSION

(FORM TB/DSB 8/1/2018)

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This checklist contains a detailed list of the documentation you will need to complete your application. **Every applicant needs to provide the following:**

1. Full application, with complete answers to each question.

2. All signature pages of application (submit a hard copy within 7 days if the application is being submitted electronically).

3. Medical documentation or letter on letterhead from a physician, medical practitioner, hospital, clinic or other medical or medically related facility, or insurance company, verifying 1) WHAT your injury is, 2) HOW your injury occurred 3) the DATE of your injury occurred. Letters that fail to indicate all three items will not be sufficient.

4. Proof of Georgia residency (see enclosed list of acceptable documentation).

5. Proof of United States Citizenship (See enclosed citizenship affidavit with instructions). **Common documents include:** birth certificate, passport, military ID. (A Georgia driver’s license does NOT qualify as proof of U.S. Citizenship)

6. Copies of written denials from other sources if applicable (i.e. private insurance, Medicaid, Medicare, waivers, etc.).

7. One (1) cost quote or estimates from each vendor, company, or organization (provider) that will provide each requested good or service (where applicable)

8. Additional documentation outlined under the specified category request for EACH good(s) or service(s) requested in the application packet.

**Helpful Hint:**

- Think about what you are requesting and find the category using the table of contents provided.

- Use the table of contents on the next page to help you find the documentation needed for your specific request(s).
1. **How do I know if I am eligible to apply for a grant?** Eligible individuals must meet the following criteria:

   a. Resident of Georgia at the time of application
   b. Citizen of the United States
   c. Sustained a traumatic brain or spinal cord injury. See definitions below:

   **Brain Injury** means a traumatic injury to the brain (cranio-cerebral head trauma), not of a degenerative or congenital nature, but arising from blunt or penetrating trauma or from acceleration-deceleration forces that is associated with any of these symptoms or signs attributed to the injury: decreased level of consciousness, amnesia, other neurologic or neuropsychologic abnormalities, skull fracture, or diagnosed intracranial lesions. These impairments may be either temporary or permanent and can result in a partial or total functional disability.

   **Spinal cord injury** means a traumatic injury to the spinal cord, not of a degenerative or congenital nature, but arising from blunt or penetrating trauma or from acceleration-deceleration forces, resulting in paraplegia or quadriplegia, which can be a partial or total loss of physical function.

   **NON-eligible injures include:**
   (a) Individuals who have had a CVA (cerebral vascular accident/stroke); or
   (b) Spinal cord dysfunction for which there are no known or obvious "injuries" to the intracranial central nervous system; or
   (c) Progressive dementias and other mentally impairing conditions; or
   (d) Depression and psychiatric disorders; or
   (e) Mental retardation and birth-related disorders; or
   (f) Neurological degenerative, metabolic, and other conditions of a chronic, degenerative nature; or
   (g) Anoxic or hypoxic episodes, allergic reactions, toxic substance reactions or any other inflammatory infections or acute medical incidents.

2. **How do I apply for a grant?** Complete an application and submit it and other required documents to the Commission. You may contact the Commission office for an application at 1-888-233-5760 or 404-651-5112. You may also apply online at www.bsitf.georgia.gov
3. **Is the Trust Fund an entitlement?**
   No. A grant from the Trust Fund is not a permanent source of funding for an individual. An eligible application is not a guarantee of receiving funds.

4. **How long will it take to review my application?**
   (a) Once staff deems your application complete (all requested documentation received) the application is date stamped and is placed in the queue with all other applications received in date stamp order. There is normally a waiting list that can last from three to nine months depending on the availability of funds and the nature of your request.
   
   (b) If your application is incomplete when it arrives, it may be necessary to contact you to request additional information, which will prolong this process.
   
   (c) The final step of the process is for the Commission to send its recommendations for funding to the Governor for final approval. This is required by our legislation.

5. **If I am approved for a disbursement, when will I receive the funds?**
   (a) Once you have been approved for a disbursement, you will receive a Provider Selection form to complete and send back to us. This form indicates the provider you have chosen.
   
   (b) The provider you have chosen will then receive a letter of authorization to provide the good or service. The provider must submit an invoice to us for the good or service rendered.
   
   (c) Upon receipt of invoice, a check will be distributed within Thirty Days - State of Georgia policy is net 30 days for payment of invoices.
   
   (d) If you have not begun to spend your award within one year of the grant award date your grant award for that specific request will be rescinded.
   
   (e) You may reapply at a later date for rescinded items if allowed by rule.
6. **How much money can I apply for?**

The Commission has set the total **maximum** distribution award cap at $10,000 per eligible applicant. This cap is **retroactive** to all previous distribution recipients. Once the maximum amount is reached the applicant is no longer eligible to apply. You may request up to the following amounts for the following categories.

- **Computers** - up to $750
- **Dental** - up to $1,000 in a twelve-month period
- **Recreation** - up to $2,500 in a twelve-month period
- **Alternative Transportation** - up to $5,000
- **Assistive Technology** - up to $5,000
- **Health and wellness** - up to $5,000
- **Vision / hearing services** - up to $5,000
- **Vocational support** - up to $5,000
- **Medical, Rehabilitative, Therapeutic services** - up to $10,000
- **Personal Support Services** - up to $10,000
- **Non-modified vehicle** - up to $10,000 (a single purchase)
- **Home Modifications** - up to $10,000
- **Modified Vehicles** - up to $15,000 (a single purchase)
- **Vehicle modifications** - up to $15,000
- **Durable Medical** - up to $10,000
- **All other requests** - up to $5,000 * (the Commission may limit request amounts for other types of request)

**Please note** - All distributions are subject to the availability of appropriated funds.

7. **Is there anything I CANNOT apply for?** The Commission does not provide funding for:

- a) any type of emergency housing (e.g. down payments, rent, mortgage/loan payments, or repairs);
- b) vehicle repairs
- c) internet service;
- d) furniture/appliances (except for front-loading washers and dryers, accessible stoves/ovens);
- e) legal expenses (e.g. court-mandated fees, fines or attorneys fees);
- f) taxes or tax penalties (e.g. sales, ad valorem, (property) or income taxes);
- g) any medications (prescriptions) or medical insurance premiums
h) moving expenses, vacations or airfare

8. Do I have to pay taxes on my award? YES. The Brain and Spinal Injury Trust Fund Commission is a tax-exempt agency and does not reimburse sales tax. The recipients is responsible for all sales taxes.

9. Will the check be made out to me or to the provider? The check will be made out to the provider / vendor.

10. Can the Trust Fund reimburse me for past expenses? No. The Trust Fund does not pay for and will not reimburse you for goods and services that you paid for prior to your application being approved.

11. If I have applied before and want to apply again, do I have to complete the entire application again? YES. You will need to complete a new application with information related to your new request.

12. Do I have to use a specific provider or can I choose my own? You may choose your own provider. The Commission may seek basic information about the provider's ability to deliver the good or service.

13. How many quotes for my item or service do I need to submit with my application? Applicants must include a minimum of one quote for each item or service requested (where applicable). Your application will not be considered complete without the quotes from vendors. (note - some items such as computers, dental services or vehicles do not require a quote during the application process. If awarded you will be required to show a quote or invoice before purchase.)

14. How do I apply for home modifications?
   
   (a) The Brain & Spinal Injury Trust Fund Commission is working with the Department of Community Affairs (DCA) to process requests for home modifications.

   (b) If you are requesting a home modification Commission staff will refer eligible applicants to DCA. You may have to work with DCA’s list of approved vendors.

   (c) Home modification requests are eligible for up to $10,000.

15. How can I reach the Commission office?

   Brain & Spinal Injury Trust Fund Commission
   2 Peachtree Street NW
   Suite 26-416
   Atlanta, GA 30303
   Phone: 404-651-5112 or 1-888-233-5760
   Fax: 404-656-9886
   Email us: DPH-info-bsitf@dph.ga.gov
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/
GEORGIA RESIDENCY REQUIREMENTS - continued

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

In order to apply for a grant from the Brain and Spinal Injury Trust Fund Commission (BSITFC), Georgia law requires every applicant to 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.

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.

Locate **one** original document on the list to bring to the Notary Public to establish your identity. Note – some of the items on the list are crossed out – those items are **NOT** eligible for application to the BSITFC.

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 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 will be presenting to the Notary Public as proof of your U.S. citizenship.

**CAUTION:** 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)

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 in the United States lawfully. Then sign your name.

5. **Make certain** that the Notary Public signs and dates the affidavit and writes when the notary commission expires. **PLEASE MAKE SURE YOU HAVE FILLED IN THE NAME OF THE SECURE AND VERIFIABLE DOCUMENT 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. Include the **ORIGINAL SIGNED AFFIDAVIT** document you presented to the Notary Public with your BSITFC application.
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:
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]
- 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.
Before you apply to the Brain & Spinal Injury Trust Fund Commission....

**(FORM TB/DSB 8/1/2018)**

- 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 [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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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) ]
Before you apply to the Brain & Spinal Injury Trust Fund Commission…

(CATEGORY REQUESTS - BELOW $5,000)

NOTE: Recipients of distributions are responsible for any and all taxes, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

❖ **Computer request - up to $750**

**Documentation required:**

1) Completed application

**Note:** Computers limited to a cost of up to $750. An additional $100 may be requested for a printer or scanner and $200 for software related to the applicant’s disability.

--If adaptive equipment is necessary an assistive technology (AT) assessment may be requested.

--The Commission will not pay for warranties or internet service.

--Quotes/invoices are not required during the application process but will be required if you are awarded.

❖ **Dental services request - up to $1,000 (within a 12-month period)**

**Documentation required:**

1) Completed application

**Note:** Awards for dental services are capped at $1,000 annually and preventive services are allowed.

Quotes/invoices are not required during the application process but will be required if you are awarded.

❖ **Recreation / hobbies services or equipment requests - up to $2,500 (within a 12-month period)**

**Documentation required:**

1) Completed application

2) A cost quote reflecting the amount of funding being requested, timeframe, or length of time for services.

   The applicant must demonstrate that the goods and services requested:

   (i) Allow for the person to be an active member of the community; (ii) Promote health and well-being; and (iii) Allow for independence in an activity the applicant would not be able to participate in otherwise.
Before you apply to the Brain & Spinal Injury Trust Fund Commission…

CATEGORY REQUESTS - UP TO $5,000

NOTE: Recipients of distributions are responsible for any and all taxes, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

❖ Alternative Transportation requests - up to $5,000

Documentation required:

- Completed application
- One (1) cost quote
- Any other additional documentation that may be required by Trust Fund staff.

NOTE: Alternative transportation includes but is not limited to cab services and public transportation.

❖ Assistive technology (AT) requests - up to $5,000

Documentation required:

- Completed application
- One (1) cost quote
- Assistive technology (A.T.) assessment which outlines how the technology meets your particular needs OR a recommendation from a credentialed therapist practicing in the SCI/TBI field (needed only for environmental control units, communication devices, computer software, etc)

❖ Health and wellness service requests - up to $5,000

Documentation required:

- Completed application
- A cost quote reflecting the amount of funding being requested, detailing:
  a. the cost of services
  b. frequency of services
  c. and length of time for services
Before you apply to the Brain & Spinal Injury Trust Fund Commission....

(FORM TB/DSB 8/1/2018)

- **Vision / hearing services requests - up to $5,000**
  
  **Documentation required:**
  
  1) Completed application
  
  2) A letter from physician stating that requested service is directly related to your injury.
  
  3) One (1) cost estimate for services
  
  4) Copies of written denials (if available) from Medicaid, Medicare, private insurance, or other sources. The Trust Fund must be the payer of last resort and reserves the right to deny request if another payer is identified.

- **Vocational support requests - up to $5,000**
  
  **Documentation required:**
  
  1) Completed application
  
  2) One (1) cost estimate for services
Before you apply to the Brain & Spinal Injury Trust Fund Commission....

(CFORM TB/DSB 8/1/2018)

**CATEGORY REQUESTS - UP TO $10,000**

**NOTE:** Recipients of distributions are responsible for any and all taxes, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

❖ **Medical, rehabilitative or therapeutic services request - up to $10,000**

**Documentation required:**

1) Completed application

2) Letter from a physician, verifying the need for the requested service or product

* For rehabilitative, neuropsychological, and other therapies:

(1) expected length of time for services, and frequency of services from an accredited medical professional (this information can be included on your quote)

(2) One (1) cost estimate for services itemized to reflect the amount of request for funding and services to be provided

(3) Copies of written denials (if available) from Medicaid, Medicare, private insurance, or other sources. The Trust Fund must be the payer of last resort and reserves the right to deny requests if another payer is identified.

❖ **Personal support services / attendant care / respite requests - up to $10,000**

**Documentation required:**

1) Completed application

2) A cost quote reflecting the amount of funding being requested, detailing all of the following:

   1) the cost of services per hour and/or per day
   2) frequency of service
   3) length of time for services
   4) name, address, phone number of the vendor

3) Copies of written denials (if available) from Medicaid, Medicare, private insurance, or other sources. The Trust Fund must be the payer of last resort and reserves the right to deny requests if another payer is identified.
Before you apply to the Brain & Spinal Injury Trust Fund Commission…

**Vehicle (non-modified) requests - up to $10,000**

**For non-modified vehicles and non-modified vans**

1. Completed application

2a) If applicant is NOT the driver: A current valid Georgia driver’s license (a provisional driver’s license is not acceptable)

2b) If the applicant IS the driver: A current valid Georgia driver’s license **renewed after** the date of injury (a provisional driver’s license is not acceptable)

3) If the applicant IS the driver: Copy of a driving evaluation **OR** a note on physician letterhead signed by a physician, stating that the applicant is able to drive

4) Medical documentation that shows the applicant has a TBI/SCI with a functional disability or a cognitive disability

**Note:**
The Commission will not consider replacement of operable vehicles.

The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible to the applicant.

The Commission will not pay for a vehicle with a salvage title vehicle or from a member of the applicant’s household.

If you have already been awarded a vehicle of any type by the Brain & Spinal Injury Trust Fund Commission, you are NOT eligible to apply for another one.

**Vehicle quotes/invoices are NOT required during the application process but WILL be required if awarded.**
Before you apply to the Brain & Spinal Injury Trust Fund Commission....

**CATEGORY REQUESTS - UP TO $10,000**

**NOTE:** Recipients of distributions are responsible for any and all taxes, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

**Home modification requests - up to $10,000**

- **Documentation required:**
  1) Completed application

  **NOTE:** The BSITFC works with the Department of Community Affairs (DCA) to administer the home modification program. Please complete the application and staff will follow-up with you regarding the next steps for home modification requests.

Requests for home modifications CANNOT increase the square footage of the home. Requests for home modifications CANNOT be combined with other requests.

**Durable medical equipment / wheelchair request - up to $10,000**

- **Documentation required:**
  1) Completed application
  2) One (1) cost quote
  3) A prescription for the equipment OR a recommendation by a therapist for the specific equipment being requested.
  4) Copies of written denials (if available) from Medicaid, Medicare, private insurance, or other sources. The Trust Fund must be the payer of last resort and reserves the right to deny request if another payer is identified.
Before you apply to the Brain & Spinal Injury Trust Fund Commission....

(CFORM TB/DSB 8/1/2018)

**CATEGORY REQUESTS - UP TO $15,000**

- **Modified Vehicle requests - up to $15,000**

  **Documentation required:**

  1) Completed application

  2a) If applicant is **NOT** the driver: A current valid Georgia driver’s license (a provisional driver’s license is not acceptable)

  2b) If the **applicant IS** the driver: A current valid Georgia driver’s license renewed **AFTER** the date of injury (a provisional driver’s license is not acceptable)

  3) If the **applicant IS** the driver: Copy of a driving evaluation **OR** a note on physician letterhead signed by a physician, stating that the applicant is able to drive

  4) If the applicant is applying for a vehicle he or she must provide medical documentation that shows you have a TBI/SCI with a functional disability or a cognitive disability

  **Note:**

  Modified vehicle include vans, pickup truck or SUV **ONLY**

  The Commission will not consider replacement of operable vehicles.

  If you have already been awarded a vehicle of any type by the Brain & Spinal Injury Trust Fund Commission you are **NOT** eligible to apply for another one.

  The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible to the applicant.

  The Commission will not pay for a vehicle with a salvage title vehicle or from a member of the applicant’s household. The Commission will not pay for vehicles that exceed Kelley Blue Book value.

  **Vehicle Quotes/invoices are NOT required during the application process but WILL be required if awarded.**
Before you apply to the Brain & Spinal Injury Trust Fund Commission…

(FORM TB/DSB 8/1/2018)

❖ For vehicle modification requests, the vehicle must meet the following guidelines - up to $15,000

**Documentation required:**

**NOTE:** Modifications to a vehicle include a wheelchair lift, lowered floors, raised roof, tie-downs, hand controls or any conversion package.

1) Completed application

2) One (1) cost estimate for services: All quotes/estimates MUST include vehicle information such as: year, make, model, and mileage. Quotes will also need to include the vendor and applicant information.

3) The vehicle to be modified must meet the following criteria:

All vehicles **under** 8 years of age and/or under 100,000 miles will qualify for vehicle modifications.

All vehicles **equal to or over** 8 years and/or over 100,000 miles must have an ASE certified mechanic certify that the vehicle has 50,000 operable miles of use remaining. The ASE mechanic may not be employed by either the seller or modifier of the vehicle.

**IMPORTANT:**

**THE COMMISSION CANNOT REIMBURSE APPLICANTS FOR GOODS OR SERVICES THAT YOU PURCHASED PRIOR TO YOUR RECEIPT OF AN OFFICIAL LETTER NOTIFYING YOU THAT YOUR APPLICATION REQUEST HAS BEEN APPROVED BY THE GOVERNOR’S OFFICE.**

**IF YOU HAVE ALREADY PURCHASED AN ITEM THAT YOU ARE REQUESTING FROM THE TRUST FUND YOUR APPLICATION OR GRANT WILL BE RESCINDED.**
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

Continued on next page
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.**

<table>
<thead>
<tr>
<th>Personal Support Services</th>
<th>Enrolled</th>
<th>Applied, waiting for response</th>
<th>Applied, not eligible</th>
<th>Not eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care Services Program (CCSP)</td>
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<td>☐</td>
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<td>Independent Care Waiver Program (ICWP)</td>
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<tr>
<td>SOURCE Waiver</td>
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<tr>
<td>Mental Retardation Waiver Program (MRWP)</td>
<td>☐</td>
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<tr>
<td>Other Waivers</td>
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<table>
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<tr>
<th>Financial &amp; Benefits Resources</th>
<th>Enrolled</th>
<th>Applied, waiting for response</th>
<th>Applied, not eligible</th>
<th>Not eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>☐</td>
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<tr>
<td>Medicare</td>
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<tr>
<td>Supplemental Security Income (SSI)</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Social Security Disability Insurance (SSDI)</td>
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</tbody>
</table>

<table>
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<tr>
<th>Other Resources</th>
<th>Enrolled</th>
<th>Applied, waiting for response</th>
<th>Applied, not eligible</th>
<th>Not eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Insurance</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Short Term Disability</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Long Term Disability</td>
<td>☐</td>
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<tr>
<td>Vocational Rehabilitation (VR)</td>
<td>☐</td>
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<tr>
<td>Veteran’s Administration</td>
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<tr>
<td>Crime Victim Compensation Fund</td>
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</table>

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 __________________________

<table>
<thead>
<tr>
<th>DESCRIPTION OF INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of Injury (Check all that apply):</td>
</tr>
<tr>
<td>☐ Traumatic Brain Injury (TBI)</td>
</tr>
<tr>
<td>Date of Injury: __________________________</td>
</tr>
<tr>
<td>Cause of Injury:</td>
</tr>
<tr>
<td>☐ Accidental fall ☐ Accidentally struck by or against an object or person ☐ Assault</td>
</tr>
<tr>
<td>☐ Self-inflicted Injury ☐ Transportation/Motor Vehicle accident ☐ Sports/Recreation</td>
</tr>
<tr>
<td>☐ Other __________________________</td>
</tr>
</tbody>
</table>

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.
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)**

<table>
<thead>
<tr>
<th>4. REQUEST:</th>
<th>Amount:</th>
</tr>
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<tbody>
<tr>
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<tr>
<td>Provider address:</td>
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<tr>
<td>Provider phone #:</td>
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<tr>
<td>How will this request allow you to be more independent?</td>
<td></td>
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<tr>
<td>How will this request allow you to be more a part of your community?</td>
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<td>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:</td>
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<tr>
<th>5. REQUEST:</th>
<th>Amount:</th>
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<tbody>
<tr>
<td>Provider name:</td>
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<td>Provider address:</td>
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<tr>
<td>Provider phone #:</td>
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<tr>
<td>How will this request allow you to be more independent?</td>
<td></td>
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<tr>
<td>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:</td>
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</tr>
</tbody>
</table>
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 www.bsitf.state.ga.us); 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 affect my eligibility; and
   3. The Commission’s determination may affect not only continued eligibility but also affect 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 information 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 effect 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 efficiently.
   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.

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
Daily Living Survey

Name_________________________________________________

Social Security # (LAST 4 DIGITS ONLY) ______________________

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

===================================================================

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.
TRANSPORTATION

4. Are you able to drive yourself?

(OONLY 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 “NO” to question 4, do you have someone who can drive you to the places you need to go?

(OONLY CHOOSE ONE ANSWER)

a) Always
b) Often
c) Sometimes
d) Rarely
e) Never

6. If you answered “NO” to question 4, is public transportation available to take you to most of the places you need or wish to go?

(OONLY 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.
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.
Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

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

(OONLY 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.
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.
HEALTH (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.
Brain & Spinal Injury Trust Fund Commission
Daily Living Survey

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
2 Peachtree Street, NW
Suite 26-426
Atlanta, Georgia 30303
Fax 404-656-9886

For Staff Use Only:

OMTS:_____________ Date received___________

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First Name ___________________ Last Name ___________________________

Last 4 digits of SSN ________________________________

Statement of Income

Please enter your household income below (a household consists of you, your spouse (if married) and any children under the age of 18 or anyone in the household that you are the legal guardian of).

Please list your household monthly income from all sources:
$________________

OR

If you do not know your monthly household income, list your annual household income from all sources:   $________________

Workers’ Compensation Questionnaire

1. Are you receiving Workers’ Compensation? _____YES _____NO

2. If YES - What is the dollar amount you are receiving?

3. What goods and services is Workers’ Compensation paying for? (Please provide documentation of your Workers’ Compensation benefits)
If you are NOT applying for a vehicle – DO NOT FILL OUT THIS FORM.

If you ARE requesting funding for a vehicle - Please fill out this form and submit with your application. There are several pages to complete. Please review and fill out ALL the pages.

BEFORE YOU BEGIN – PLEASE READ:

➢ The Commission will not consider replacement of operable vehicles
➢ The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible for the applicant

Applicant’s Name: ________________________________________________________________

Name of the Driver if other than the applicant: ____________________________________________________________

Does this driver have a vehicle?   Yes__________      No__________

Driver’s Relationship to Applicant:

Driver’s License Number of the driver: ________________________________________________________________

Please include with this form - a photocopy of the driver’s license of the person who will be the driver of the vehicle and medical documentation that shows the applicant has a TBI/SCI with a functional disability or a cognitive disability. (Please be sure the photocopy is clear – if it is not you will be asked to re-send and it will delay the application process.)

Please answer all of the questions below. Unanswered questions will render the application incomplete and may delay the review process. You may use additional pages if necessary.
Applicant’s Name____________________________________________________

1. Does the applicant currently own a vehicle? ___________YES  ___________NO

2. If YES what is the year_____ make_______ model_________ mileage____________?

3. Is there a vehicle registered in the applicant's name? ___________YES  ___________NO

4. Why is the applicant requesting funding for another vehicle?

5. Are there other vehicles in the home? ___________YES  ___________NO

6. If YES – does the applicant have access to those vehicles? (please explain)

7. If awarded – Will the requested vehicle be used for the direct, sole benefit of the applicant? ___________YES  ___________NO (please explain)

8. How has the applicant been getting around since the injury?

9. Does the applicant use a _____motorized wheelchair  ____ manual wheelchair

_________Both?  ______Neither? If both, please explain.

I understand that falsifying information or providing false certification(s) may be subject to civil or criminal penalties as provided by Georgia state law or disqualification from applying to the BSITFC.
Signature of the Applicant ___________________________________________ Date __________

Signature of Driver _________________________________________________ Date _______________
(if different from applicant)

NOTE: Recipients of distributions are responsible for **any and all taxes**, including but not limited to sales, ad valorem (property), income taxes or tax penalties, on services or items purchased with distribution funds.

**Vehicle (non-modified) requests – up to $10,000**

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<th><strong>Documentation required:</strong></th>
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For non-modified vehicles and non-modified vans

1) Completed application

2a) If applicant is **NOT** the driver: A current valid Georgia driver’s license (a provisional driver’s license is not acceptable)

2b) If the applicant **IS** the driver: A current valid Georgia driver’s license **renewed AFTER** the date of injury (a provisional driver’s license is not acceptable)

3) Copy of a driving evaluation **OR** a note on physician letterhead signed by a physician, stating that the applicant is able to drive

4) Medical documentation that shows the applicant has a TBI/SCI with a functional disability or a cognitive disability

**Note:**
The Commission will not consider replacement of operable vehicles.

The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible or unavailable to the applicant.

The Commission will not pay for a vehicle with a salvage title vehicle or from a member of the applicant’s household.

If you have already been awarded a vehicle of any type by the Brain & Spinal Injury Trust Fund Commission you are NOT eligible to apply for another one.
Quotes/invoices are NOT required during the application process but WILL be required if you are awarded.

Commission staff will contact applicant about specific requirements and additional documentation for home modification requests. Requests for home modifications CANNOT increase the square footage of the home.

- **Modified Van requests – up to $15,000**

  **Documentation required:**

  1) Completed application

  2a) If applicant is NOT the driver: A current valid Georgia driver’s license (a provisional driver’s license is not acceptable)

  2b) If the applicant IS the driver: A Current valid Georgia driver’s license renewed AFTER the date of injury (a provisional driver’s license is not acceptable)

  3) Copy of a driving evaluation OR a note on physician letterhead signed by a physician, stating that the applicant is able to drive

  4) Medical documentation that shows the applicant has a TBI/SCI with a functional disability or a cognitive disability

**Note:**

The Commission will not consider replacement of operable vehicles.

The Commission will not consider applications for an additional vehicle in a household unless the existing vehicle is inaccessible or unavailable to the applicant.

The Commission will not pay for a vehicle with a salvage title vehicle or from a member of the applicant’s household.

If you have already been awarded a vehicle of any type by the Brain & Spinal Injury Trust Fund Commission you are NOT eligible to apply for another one.

Quotes/invoices are NOT required during the application process but WILL be required if you are awarded.
For vehicle modification requests, the vehicle must meet the following guidelines – up to $15,000

Documentation required:

**NOTE:** Modifications to a vehicle include a wheelchair lift, lowered floors, raised roof, or any conversion package.

1) Completed application

2) One (1) cost estimate for services: All quotes/estimates MUST include vehicle information such as: year, make, model, and mileage. Quotes will also need to include the vendor and applicant information.

3) The vehicle to be modified must meet the following criteria:

All vehicle **under** 8 years of age and/or under 100,000 miles will qualify for vehicle modifications.

All vehicle equal to or over 8 years and/or over 100,000 miles must have an ASE certified mechanic certify that the vehicle has 50,000 operable miles of use remaining. The ASE mechanic may not be employed by the seller or modifier of the vehicle.