**Massachusetts Rehabilitation Commission**

**STATEWIDE HEAD INJURY PROGRAM Application**

**600 Washington Street 2nd Floor, Boston, MA 02111**
**FAX: 617-204-3889**
**(617) 204-3852 1-800-223-2559**

**1. NAME** _____
**Last Name First Name Middle Initial**

**Maiden or Birth Name**_____

**Name of Parent(s) if minor child** _____

**2. Date of birth** _____ **3. Age** ___ **4. Social Security No.** ___-___-___

**5. Address** _____
**No. Street Town/City State Zip Code**

**6. Phone No. Home (**_____**)**_____ **Work (**_____**)**_____

**Cell (**___**)**_____

**7. Mailing address (if different from above)** _____

_____

**8. E-mail Address:** _____

**9. a. Are you a Veteran?** ☐ **Yes** ☐ **No**

**b. Did you serve in:** ☐ **Iraq/Afghanistan** ☐ **Gulf War** ☐ **Vietnam**

☐ **Korea** ☐ **WWII** ☐ **Other** _____

**10a. Do you speak and understand English?** **Yes** ☐ **No** ☐

**10b. If no, what language do you speak and understand?** _____

**11a. Are you deaf or hard of hearing?** ☐ **Yes** ☐ **No**

**11b. Do you use a TTY?** ☐ **Yes** ☐ **No**

**12. Sex:** **M** ☐ **F** ☐

**13. CURRENT LIVING SITUATION (check one)**

☐ Living at home with family
☐ Living alone in a home/apartment
☐ Living in a home/apartment with others
☐ Living in a community residence or apartment with supervisory staff
☐ In a rehab or chronic care hospital
☐ In a skilled nursing home/ long-term care facility
☐ In a hospital
☐ In a correctional institution
☐ In a shelter
☐ Homeless
☐ Other (Specify :_____)

**14. Name and address of program, hospital or facility, if other than home or apartment:**

_____ **Phone No. (_____)_____**

**Address:** _____
**No. Street Town/City State Zip Code**

***15. Do you have a court-appointed guardian? Yes☐ No☐**

**Name of Guardian:** _____ **Relationship:** _____

**Address of Guardian:** _____

**Phone No. (___)_____**

***IF YOU ANSWERED "YES" ON ITEM 15, YOU MUST INCLUDE A COPY OF COURT DECREE DOCUMENTING GUARDIANSHIP STATUS***

**16. Health Insurance. Please check and complete all that apply:**

☐ **Medicaid\MassHealth: Number:**_____

☐ **Medicare: Number:** _____

☐ **Other: Name:** _____

**Number:** _____

**17. If you are currently in private or public school and are under the age of 22, are you receiving special education services?**

☐**Yes** ☐**No**

## TRAUMATIC BRAIN INJURY INFORMATION

**1. Date of brain injury:** ☐ ☐ ☐ _____
Month Day Year Age at time of injury

**2. What were the circumstances of this injury? (check one)**

**a)** ☐ **ACCIDENT (check type):**

☐ **Motor vehicle accident:** ☐ **Driver** ☐ **Passenger** ☐ **Pedestrian**

☐ **Motorcycle accident** ☐ **Bicycle/Moped accident**

☐ **Boating accident** ☐ **Recreational vehicle accident**

☐ **Sports accident** ☐ **Industrial accident**

**b)** ☐ **ASSAULT (check type):** ☐ **Child abuse** ☐ **Domestic violence**

☐ **Gunshot wound** ☐ **Knife wound** ☐ **Other** _____

**c)** ☐ **FALL**

**d)** ☐ **COMBAT/WAR**

**e)** ☐ **OTHER (describe)**_____

**3. If a motorcycle, moped, bicycle, recreational vehicle, sports accident, or combat-related injury, were you wearing a helmet? Yes** ☐ **No** ☐

**4. If a motor vehicle accident, were you wearing a seat belt? Yes** ☐ **No** ☐

**5. Did you lose consciousness? Yes** ☐ **No** ☐ ☐ **Unsure**

**Duration of unconsciousness:** ☐ **Brief** ☐ **Less than 1 hr.** ☐ **1 - 24 hrs.**

☐ **More than 24 hours (specify _____)**

**6. Were you evaluated/treated/admitted to a hospital? ☐ Yes ☐ No**

**a. Name of hospital_____**

**b. Address _____**

**c. If admitted, dates of admission: ____/____/___ - ____/____/___**

**7. If you were not evaluated or treated at a hospital, who provided evaluation or treatment for your brain injury?**

**a. Name of Physician/Clinic where evaluation or treatment was provided:**

**_____**

**b. Address _____**

**_____**

**c. Date of Evaluation/Treatment _____**

**8. Did you receive treatment for your traumatic brain injury at a rehabilitation hospital or clinic? ☐ Yes ☐ No**
**If yes, list below:**

| Name of hospital / program | Dates of service | Address |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**9. Have you been hospitalized or have you received out-patient treatment for a psychiatric / psychological disorder? ☐ Yes ☐ No**

**Where?_____**

**Address _____**

**10. Have you ever been hospitalized or have you received out-patient treatment for substance abuse?** ☐ **Yes** ☐ **No**

**Where?** _____

**Address** _____

**11. Have you received, or are you receiving services from:**

| | | |
|---|---|---|
| **Dept. of Developmental Services (previously DMR)** | ☐ **Yes** | ☐ **No** |
| **Dept. of Mental Health (DMH)** | ☐ **Yes** | ☐ **No** |
| **Dept. of Youth Services (DYS)** | ☐ **Yes** | ☐ **No** |
| **Dept. of Children and Families (previously DSS)** | ☐ **Yes** | ☐ **No** |
| **Mass. Commission for the Blind (MCB)** | ☐ **Yes** | ☐ **No** |
| **Mass. Commission for the Deaf & Hard of Hearing (MCDHH)** | ☐ **Yes** | ☐ **No** |

**Name of person completing this form, if other than applicant:** _____

**Relationship** _____ **Phone No. (_____)**_____

**Address** _____
**No. Street Town/City Zip Code**

**Please read carefully before signing:**
***I understand that the Massachusetts Rehabilitation Commission is an agency of the Executive Office of Health and Human Services (EOHHS) and thus participates in the MassCARES information technology initiative. I authorize MRC to release my client identifier information as necessary to MassCARES for the purpose of improving the Commonwealth's ability to manage and deliver cost-effective services.***

***I understand that unemployment and wage information may be shared between Department of Revenue (DOR) and the Massachusetts Rehabilitation Commission.***

_____ _____
**Signature of Applicant** **Date**
**(Required, if over age 18 and not under court-appointed guardianship)**

_____ _____
**Signature of Legal Guardian** **Date** **Signature of Parent** **Date**
**(Copy of Court Decree Required)** **(Required if under age 18)**

***APPLICATIONS WITHOUT REQUIRED SIGNATURES CANNOT BE PROCESSED***

**How did you hear about SHIP? _____**

**<u>Race/National Origin</u> (this information is voluntary)**

☐ **Asian** ☐ **Pacific Islander** ☐ **Black/African-American**

☐ **Latino/Hispanic** ☐ **Caucasian (white)** ☐ **Other _____**

☐ **Native American** ☐ **I do not wish to furnish this information**

**THIS INFORMATION IS UTILIZED BY THE STATEWIDE HEAD INJURY PROGRAM TO ASSIST IN MULTICULTURAL OUTREACH**

**The Massachusetts Rehabilitation Commission does not discriminate on the basis of race, color, national origin, gender, age, or handicap. Any person who has questions or concerns about agency practices may contact the Affirmative Action Administrator at the Massachusetts Rehabilitation Commission, Administrative Office, 600 Washington Street, Boston, MA 02111.**
**Phone (617) 204-3762 or 1-800-223-2559.**

**STATEWIDE HEAD INJURY PROGRAM**
**Authorization for Release of Information**

**I understand that the Massachusetts Rehabilitation Commission (MRC) requires certain medical and other information in order to establish my eligibility for the Statewide Head Injury Program (SHIP).**
**All information that MRC-SHIP requests and receives from other sources will be used for purposes connected with my services and shall be confidential to this agency.**

**Except as otherwise noted, I authorize the individuals, agencies, hospitals, institutions, and facilities below to release reports and other information to SHIP for purposes of my eligibility and services. I also authorize SHIP to release information from my records to these same individuals and organizations only when necessary for better coordination of services.**

**I understand I may withdraw this authorization for any of these sources at any time by giving written notice to SHIP. Otherwise, it will remain valid for 1 year.**

**Approved Sources**

- **Department of Mental Health**
- **Department of Developmental Services**
- **Department of Public Health**
- **Department of Transitional Assistance**
- **Division of Employment Security**
- **Community rehabilitation and treatment programs**
- **Public & private schools or colleges**
- **Drug and alcohol clinics**
- **Disability Law Center**
- **Mass. Commission for the Blind**
- **Family members**
- **Veteran's Administration**
- **MRC-Community Living Division**
- **Disability Determination Service**
- **Independent living centers**
- **Correctional institutions**
- **Client Assistance Program (CAP)**
- **Employers**
- **Department of Industrial Accidents**
- **MRC-Vocational Rehabilitation**
- **Counselors**
- **Exec. Office of Health & Human Services**
- **Insurers**
- **Other (specify below)**

***Exceptions or additions to above list:***

_____ _____

**Applicant's Signature** **Date** **Parent/Guardian's Signature** **Date**

*Please Keep This Page for Future Reference*

**STATEWIDE HEAD INJURY PROGRAM**
**Information for New Applicants**

**Prerequisites for Eligibility Determination**

**SHIP requires that Massachusetts residency be established prior to eligibility determination.**

**Appropriate Signature**

**On all documents requiring signatures, the following shall be considered appropriate.**

1. **If the applicant is under age 18, the signature of parent or guardian is sufficient.**

2. **If the applicant is age 18 or older, their own signature is required, except that:**

    a. **If the individual is physically incapable of signing, they may designate another sign for them and such should be noted on the form.**

    b. **If the individual is capable of making a mark on the form, that mark should be witnessed by another person also signing the form.**

    c. **If the individual has given another person power of attorney for the purpose of signing such documents, the person with power of attorney may sign. A copy of this authorization must be submitted.**

    d. **If the person has been declared legally incompetent, the person who has been appointed guardian by the court should sign the form. A copy of the Massachusetts guardianship order must be submitted.**

3. **Consistent with a philosophy of family involvement, parents or other appropriate family members/significant others or representatives are encouraged to participate in eligibility, service planning and implementation unless the applicant or individual who is of legal age, and not under a court-appointed guardianship, objects to such Involvement.**

**(OVER)**

## Case Closure

**An individual's case shall be closed for any of the following reasons:**

**a. Change in residency status**
**b. False representation of financial need status**
**c. Refusal to submit requested documentation supporting financial need**
**d. Refusal to contribute available financial resources toward SHIP-funded residential services**
**e. Refusal to participate in SHIP services**

## Eligibility

**Eligibility for SHIP services is based on:**

**a. Documentation of a traumatic brain injury**
**b. Significant impairment of behavioral, cognitive and/or physical functioningresulting primarily from traumatic brain injury**
**c. Demonstrated ability and intent to participate in community-based services**

## Right of Appeal

**If an individual or legal guardian disagrees with SHIP's determination of ineligibility or with a decision to close his/her case, he/she may file a request for appeal within 30 calendar days of such notification, in accordance with 107 CMR 12.09.**
**To request an appeal, write to: SHIP Director, Statewide Head Injury Program, Massachusetts Rehabilitation Commission, 600 Washington Street, Boston, MA 02111.**

**All records and information concerning applicants are considered confidential, for the exclusive use of SHIP. Applicants may withdraw authorization regarding records at any time by giving written notice to SHIP.**

Thông tin trong bức thư này rất quan trọng. Đó là về mẫu ghi danh vào Chương Trình Thương Tích Nơi Đầu Toàn Quốc và xin các dịch vụ có sẵn cho quý vị. Xin dịch bản này sang ngôn ngữ của quý vị.

La información que contiene esta carta es importante.
Se refiere a su solicitud ante el
Statewide Head Injury Program *(Programa estatal por traumatismo craneal)*
y los servicios con los que usted puede contar.
(Por favor tradúzcalo)

Les informations contenues dans cette lettre sont importantes.
Elles concernent votre demande au programme
Statewide Head Injury ainsi que les services qui peuvent
être mis à votre disposition.
Veuillez la faire traduire.

A informação contida nesta carta é importante.
Trata-se da sua inscrição ao Programa
Statewide Head Injury *(Programa Nacional de Ferimentos Na Cabeça)*
e os serviços que podem estar `a sua disposição.
Favor traduzir esta informação.

Enfòmasyon nan lèt sa a enpòtan.
Li pale de aplikasyon ou te fè pou Pwogram
nan tout Eta Massachusetts la sou Maladi nan Tèt
la avèk sèvis ke ou ka kalifye pou yo.
Tanpri fè on moun tradwi l pou ou.

Данное письмо содержит важную информацию.
Она касается вашей заявки, поданной в Statewide Head
Injury Program, и предлогаемых вам услуг.
Письмо требует перевода.

ពត៌មាននៅក្នុងលិខិតនេះមានសារៈ
សំខាន់ដោយសារវានិយាយ
អំពីការដាក់ពាក្យរបស់អ្នកដែលអាចទទួលយកបាននូវសេវានិងកម្ម
វិធី Statewide Head Injury.

這信內的資料是十分重要。
是關於你申請麻州腦創傷計劃，而可能適用於你的服
務。請將它翻譯。

این نامه حاوی اطلاعات مهمی میباشد. این نامه راجع به درخواستنامه شما درمورد برنامه جراحت سر ایالتی (Head Injury Program) و خدماتی که ممکن است در دسترس شما باشد میباشد. لطفا آنرا بدهید برایتان ترجمه کنند.