COVID-19 Financial Assistance Program

Sponsored by the Brain Injury Association of NH

Dear Applicant,

Thank you for your interest in the **COVID-19 Financial Assistance Program** sponsored by the Brain Injury Association of New Hampshire.

The purpose of the program is to assist individuals during these challenging times. The enclosed application needs to be completed and returned to:

COVID-19 Financial Assistance Program
Brain Injury Association of NH
52 Pleasant Street
Concord, NH 03301

A one-time fund of $500 per family will be made available to brain injury survivors and family members who are struggling in the aftermath of the pandemic. However, there are no restrictions on what may be requested except that it must be related to situations people are dealing with as a result of the pandemic.

Guidelines:

- Funds are only available for brain injury survivors and family members that reside in New Hampshire. Requests must be specifically connected to the coronavirus. Requests for more generic rehab or medical services will not be accepted.

Examples of what the financial assistance may be used for include (but are not limited to):

- Purchasing food, paying rent or utilities, etc. for those who are laid off, furloughed, or otherwise out of work.
- Securing Wi-Fi or Internet services so that interpersonal connections can be maintained.
- Purchasing equipment for a computer, such as a microphone or camera, so that video conferencing capability is established.

In order to apply, please:

- Complete a brief application that can be found at www.bianh.org.
- Write a brief, (one-page maximum) letter to the Brain Injury Association of New Hampshire answering the following questions:

  What happened/how did you receive your brain injury?

  What type of assistance do you need and how will the funding assist you?

You may email the initial request, but we also ask you to mail a written or typed copy with your signature on it.

- If we are not acquainted with you, you will need to provide medical documentation of your brain injury.
- You may email the initial request mail@bianh.org, but we also ask you to mail a written or typed copy with your signature on it to BIANH, 52 Pleasant St., Concord, NH 03301.
- Tell us who the check should be made out to and in what amount. CALL us at 225-8400 if you have questions or need assistance!

Policies:

- The Association reserves the right to verify any facts or statements made in the initial letter. The applicant will cooperate with same, including signing releases if so requested.
- Every effort will be made to review/reply to requests within seven business days, and checks, if approved, to be issued within 10 business days.
- Checks will only be issued directly to grocery stores, landlords, utilities, etc., not to individuals.
- The Association reserves the right to approve or disapprove any requests. If approved, BIANH will provide an amount up to but not greater than the requested amount based upon available funding.
- This program provides one-time assistance.
- Individuals receiving services under a Community Care Waiver are not eligible.

Applications also need to have a signed release and possibly need to provide medical documentation of a brain injury.

If you have problems completing any part of the application, leave blank, if needed we will follow up with you.

If you have any questions or need assistance in completing this application, please call at 603-225-8400.

Sincerely,

COVID-19 Financial Assistance Program Committee

COVID-19 Financial Assistance Program

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Description of the Program

Purpose: To support individuals living with a brain injury and their families during these challenging times.

Eligibility:

1. Have a medically documented brain injury
2. Not eligible for the Community Care Waiver
3. Financial hardship
4. Modest level of income
5. Resident of New Hampshire

Limits:

$500 per individual/family
Restrictions: One grant awarded per individual/family
Applications will be reviewed for as long as funds are available.

Process:

1. All applications are to be sent to the Brain Injury Association of NH
2. Applicants will be notified if his/her application is not complete
3. Completed applications will be reviewed by the Committee
4. Applicants will be notified by mail/phone of the Committee's decision

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Date: _____

Name: _____

Mailing Address: _____

_____

Phone number: _____

Email address: _____

Date of Birth: _____

Referred by (Name/Organization): _____

Diagnosis: ___ Traumatic Brain Injury

___ Stroke

___ Brain Tumor

Other _____

Do you receive any services on the Home and Community Based Care (HCBC) Waiver?

___ Choices for Independence (CFI)

___ Acquired Brain Disorder (ABD)

___ Developmental Disability/Intellectually Disability (DD/ID)

When did you receive your injury/ diagnosis? _____

For what purpose are you requesting funding?

_____

_____

_____

_____

_____

How much Funding are you requesting: $_____

Financial Information: Income

What is your present monthly income **after taxes**?

Total Monthly Household Income	$

Financial Information: **Expenses**

Please estimate your monthly living expenses

Monthly Expense	**Household**
Rent/Mortgage	$
Utilities (Heat, Electric, etc)	$
Phone	$
Cell Phone	$
Out of Pocket Medical Expenses	$
Total Monthly Expenses	$

Available Cash Funds

Funds Available	**Amount**
Savings	
Checking	
Total Funds Available	

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PROFESSIONAL AUTHORIZATION
FOR RELEASE OF INFORMATION

I _____ authorize the Brain Injury Association of NH
(Individual's Name/Guardian)
to review and obtain copies of all medical, hospital or other pertinent records or information in order to assist in providing services and in developing a service plan for

_____
(Individual's Name DOB)

I authorize the Brain Injury Association of NH to share information received with any institution that through a private or public funded program is a consideration for or is actually paying for all or part of my program.

I also give permission to discuss any medical, hospital or other pertinent records or information with any contact you provide to us to assist in seeking services and payments for such services.

I have had this form read and explained to me and understand its contents. I agree that a photocopy of this authorization be accepted with the same authority as the original.

I permit the use of facsimile or other electronic devices in transferring my records as needed. Sender assures all due care to protect confidentiality of records in using electronic devices.

This consent shall expire on _____

Signed _____ Date _____
Self/Guardian

Guardian's Phone Number _____

Individual's Address _____

_____

Individual's Phone Number _____

Witness _____

Relationship _____