DEPARTMENTAL MEMORANDUM
MAD-MR: 15-22
DATE: 11/24/2015

TO: INCOME SUPPORT DIVISION AND MEDICAL ASSISTANCE DIVISION
FROM: NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION
THROUGH: SHARI ROANHORSE-AGUILAR, EXEMPT SERVICES AND PROGRAMS BUREAU CHIEF, MEDICAL ASSISTANCE DIVISION
BY: LINDA GILLET, BRAIN INJURY PROGRAM MANAGER, EXEMPT PROGRAMS AND SERVICES BUREAU
SUBJECT: NM BRAIN INJURY SERVICES FUND (BISF) PROGRAM APPLICATION

GENERAL INFORMATION
This form will be for public use

FILING INSTRUCTIONS
Please make the following changes to the MAD forms manuals:

REPLACE MAD 386 Revised 6/10/14 BISF Program Application

Please address any questions concerning these guidelines to Linda Gillet, LindaB.Gillet@state.nm.us or call (505) 827-7218.

Attachment: MAD 386 Revised 10/01/2015 Application Short-Term Services for Brain Injury
**NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM**  
**HUMAN SERVICES DEPARTMENT**  
Medical Assistance Division

### A. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>1. Name (Last, First, Middle Initial)</th>
<th>2. Social Security Number</th>
<th>3. Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>4. Sex:</th>
<th>5. Marital Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Female</td>
<td>☐ Married</td>
</tr>
<tr>
<td>☐ Male</td>
<td>☐ Single</td>
</tr>
<tr>
<td></td>
<td>☐ Divorced</td>
</tr>
<tr>
<td></td>
<td>☐ Widowed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Ethnicity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Hispanic</td>
</tr>
<tr>
<td>☐ Caucasian</td>
</tr>
<tr>
<td>☐ Native American</td>
</tr>
<tr>
<td>☐ Asian</td>
</tr>
<tr>
<td>☐ African American</td>
</tr>
<tr>
<td>☐ Other (specify):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Primary Language:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ English</td>
</tr>
<tr>
<td>☐ Spanish</td>
</tr>
<tr>
<td>☐ Navajo</td>
</tr>
<tr>
<td>☐ Other (specify):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Veterans Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Are you a Veteran of the US Armed Forces: ☐ Yes ☐ No (If yes, answer B and C.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. If “Yes”, please list your military dates of service and describe your Veterans status, or provide a copy of your DD214 with this application.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dates of Military Service:</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Veterans Status:</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>C. Do you have a documented service-connected disability?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>
9. Physical Address (Address, City, State, Zip Code, County)

10. Mailing Address (Address, City, State, Zip Code, County)

11. Phone Number (with area code): Alternate Phone Number (with area code):

12. Are you a resident of New Mexico? □ Yes  □ No
(To qualify for the New Mexico Brain Injury Services Fund Program you must be a resident of the State of NM.)

13. Contact Person (Family member, Legal Guardian, or friend assisting in the completion of this application)
   Name: ___________________________
   Relationship: _______________________
   Phone Number (with area code): _______________________

B. CURRENT SITUATION

14. Reason for Application
   A. Please list type of Brain Injury and any information on when, where, and how the Brain Injury was acquired.

15. Name of person completing form, if other than the person with a Brain Injury or a family member.

16. Emergency Contact Information
   Name: ___________________________
   Address: ___________________________
   Relationship: _______________________
   Phone Number (with area code): _______________________

17. Signature of Applicant, Parent, or Legal Guardian
   ____________________________       ____________________________
   Signature                      Date
# New Mexico Brain Injury Services Fund (BISF) Program

**Human Services Department**

**Medical Assistance Division**

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**DO NOT FILL SECTIONS ON THIS PAGE**

TO BE COMPLETED BY SERVICE COORDINATOR ONLY

<table>
<thead>
<tr>
<th>Service Coordination Agency</th>
<th>Date Referred</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Service Coordinator</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 Code(s)</th>
<th>TBI</th>
<th>Other ABI</th>
<th>Date of Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

List codes here:

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<table>
<thead>
<tr>
<th>Applicant Qualifies / Approved</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Applicant Qualifies / Approval Pending Allocation</th>
<th>Date Allocation Opened</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Applicant Does Not Qualify / Denied</th>
<th>Date Denial Mailed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

(Appeal Procedures Mailed)

<table>
<thead>
<tr>
<th>Service Coordination Staff Signature</th>
</tr>
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<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Start of Service Date</th>
<th>Inactivation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REFERRED FOR:**

- Life Skills Coaching Assessment / SC Agency | Date
- Crisis Interim Services | Date

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If denied, state reason(s) below:

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[Form completed sections]

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MAD 386 Revised 10/1/15 page 3
**NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM**  
**HUMAN SERVICES DEPARTMENT**  
Medical Assistance Division

**RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

**Date:** 

<table>
<thead>
<tr>
<th>Applicant’s Name</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Address</th>
<th>Phone Number (w/area code)</th>
<th>City, State, Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

“I, the undersigned, hereby give the following provider(s) listed in Section A authorization to supply relevant protected health information (PHI) about my Brain Injury condition to the New Mexico Human Services Department (HSD) / Medical Assistance Division’s Brain Injury Services Fund (BISF) Program and its contracted provider, as noted in Sections B. I understand that this information is needed by the Human Services Department and the designated BISF Contract Provider in order to establish BISF Program eligibility and provide appropriate services for me.”

“I also authorize the BISF Contract Provider, noted in Section B, to receive, use, and/or disclose the protected health information (PHI) I have selected. Should a referral to another BISF Service Provider be necessary, my BISF Service Coordination agency is authorized to disclose my PHI to the BISF Service Providers serving my region, noted in Section C. I understand that the PHI exchanged between BISF Service Providers will be related to my Brain Injury and the services I receive through the BISF Program.”

The authorization in Section A allows only the release of information identified. Please indicate exactly which records you are designating for release (Section A), to whom (Sections B and C) and within what time period (or indicate, “All dates of service”). It is understood that any information obtained will be treated as confidential.

**Section A**

<table>
<thead>
<tr>
<th>Please Check</th>
<th>Type of Information Required:</th>
<th>Enter Provider’s/Physician’s Name and Location (City/Address)</th>
<th>Service Date(s) To/From</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Records (ICD -10 Code) Verifying Brain Injury Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Physician’s Statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Supporting Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Other Diagnoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Neuropsychological Evaluation(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Complete Medical Record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Hospital Admission/Discharge Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Mental Health/Substance Abuse Records</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Section B: All applications will be processed through the Goodwill Industries of NM Metro Office. Check the Service Coordination Provider for the region in which you reside. (See attached map for regions.)**

<table>
<thead>
<tr>
<th>Please Check</th>
<th>Applicant’s Service Region</th>
<th>BISF Service Coordination Provider Authorized To Use or Disclose PHI</th>
<th>Address of Authorized Regional BISF Service Coordination Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Metro</td>
<td>Goodwill Industries of NM</td>
<td>5000 San Mateo NE, ABQ, NM 87109</td>
</tr>
<tr>
<td>□</td>
<td>NW</td>
<td>Goodwill Industries of NM</td>
<td>1820 E. Highway 66, Gallup, NM 87301</td>
</tr>
<tr>
<td>□</td>
<td>NE</td>
<td>Goodwill Industries of NM</td>
<td>3060 Cerrillos Road, Santa Fe, NM 87507</td>
</tr>
<tr>
<td>□</td>
<td>SE</td>
<td>Goodwill Industries of NM</td>
<td>2601 N Main, Roswell, NM 88201</td>
</tr>
<tr>
<td>□</td>
<td>SW</td>
<td>Goodwill Industries of NM</td>
<td>2407 W. Picacho St., Las Cruces, NM 88007</td>
</tr>
</tbody>
</table>
Section C (Check the Statewide Crisis Interim Provider to access referred and authorized services.)

<table>
<thead>
<tr>
<th>Please Check</th>
<th>Applicant's Service Region</th>
<th>Brain Injury Crisis Interim Provider Authorized To Receive or Use the PHI</th>
<th>Address of Authorized Regional BISF Crisis Interim Provider Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Statewide</td>
<td>HelpNet. LLC</td>
<td>PO Box 159, Espanola, NM 87532</td>
</tr>
</tbody>
</table>

I understand that I may review and copy the information to be disclosed, by requesting a copy from the identified BISF Service Coordination agency. I may revoke this authorization at any time, but to do so, I must notify the BISF Service Coordination agency in writing. Such revocation will not apply to actions that any of my BISF Service Providers have taken in reliance of this Authorization. I also understand that the PHI, which I authorize any person or entity related to the BISF Program to receive, may no longer be protected by Federal law and regulations the disclosing parties/physicians, their affiliates, employees, and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

This authorization is valid from ________ Date ________ until ________ Date ________
(If end date is not specified, this authorization will expire 12 months from the date of signature.)

Name of Applicant

Name of Parent or Legal Guardian (if applicable)

Signature of Applicant, Parent, or Legal Guardian

Date

If signed by Legal Guardian, provide description of legal authority to act on behalf of applicant. Please attach legal documentation, if you are the Legal Guardian or Holder of Power of Attorney for healthcare decisions.

If you have any questions, please contact:
The Brain Injury Program
Medical Assistance Division / ESPB
2025 S Pacheco, PO Box 2348
Santa Fe, NM 87504
505-827-7218

MAD 386 Revised 10/1/15 page 5
NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

Assurances

I, (print name) __________________________ agree to provide complete
and accurate information needed to determine eligibility for myself and/or other family members for whom
I am applying. I understand that I will be subject to legal action for recovery of amounts of assistance to
which I am not entitled. I further understand that anyone who participates in deception or falsification in
connection with this application or any BISF Service Coordination or Life Skills Coaching Assessment is
subject to the criminal penalties prescribed by law. I understand the questions in this application, and I
confirm my answers are correct and complete to the best of my knowledge.

Signature of Applicant or Representative __________________________ Date __________

Signature of Guardian __________________________ Date __________
(Required if applicant is under 18 years of age or has a court appointed legal guardian.)
Residency Affidavit

I, (print name) ____________________________, am a resident of the State of New Mexico, as described below. I am officially living in New Mexico. I understand that a false claim will subject me to immediate termination of services from the New Mexico Brain Injury Services Fund Program.

Signature of Applicant, Parent, or Legal Guardian ____________________________ Date ___________

If not signed by Applicant, specify signatory’s relationship to Applicant: ____________________________

Reason Applicant is unable to sign (if applicable): ____________________________
NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM
HUMAN SERVICES DEPARTMENT
Medical Assistance Division

Request for Documentation of Brain Injury Diagnosis
May be completed with the assistance of a Service Coordinator.

Date: ______________________

Dear Dr.: ____________________________

Your patient, (print name) ____________________________, who resides in ____________________________ County, has applied for services from the NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM, which provides short-term services to individuals with a confirmed diagnosis of BRAIN INJURY and who have crisis needs. Your patient has completed a RELEASE OF INFORMATION to allow his/her BISF Service Coordinator to receive information from you about his/her brain injury (see page 4-5). Your assistance in qualifying your patient for BISF services is needed.

Please supply this patient or your patient's BISF Service Coordinator documentation of his/her brain injury. Attached to this application is the Confirmation of ICD-10 Code Form. The code(s) supplied must support a qualifying diagnosis for Traumatic Brain Injury (TBI) and/or other Acquired Brain Injuries, such as stroke, aneurysm/vascular lesions of the brain, brain tumor, anoxia, brain infections, lightning/electrical shock, exposure to toxic or chemical substances, and shaken baby syndrome. The BISF Program will determine if the code(s) supplied qualifies the individual for short-term services. Please fill out this form and return to Goodwill Industries of NM METRO Office at 5000 San Mateo NE, Albuquerque, NM 87109. Alternatively, a brief letter, signed by you, stating that this patient has a Brain Injury diagnosis, including the specific qualifying ICD-10 code(s), and information about when and how the Brain Injury was acquired, will suffice. If you have any questions about this matter, please refer to the information in this packet, which your patient received from the BISF Program. If you need further clarification, please feel free to call me at (505) 827-7218.

We understand that your time is very important and thank you for your help in qualifying your patient for the BISF Program. Since this is a short-term program, your timely response is critical in putting your patient's services in place.

Sincerely,

Linda Gillet, Ph.D.
Brain Injury Program Manager
Medical Assistance Division
Human Services Department
NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM  
HUMAN SERVICES DEPARTMENT  
Medical Assistance Division  

Confirmation of ICD-10 Code  

To be completed by Applicant’s Licensed Physician (M.D. or D.O.) Physician Assistant, Certified Nurse Practitioner and/or Licensed Psychologist.  

I confirm that my patient, named below, has been diagnosed with a BRAIN INJURY and that the ICD-10 code data specified for this patient represents a true and accurate diagnosis to support the qualifying condition. List any and all qualifying codes below to support the diagnosis.  

Name of Patient with Brain Injury (Printed Name)__________________________  

Social Security # of Patient ____________________________________________  

ICD-10-CM Code __________________________ ICD-10-CM Code __________________________  

ICD-10-CM Code __________________________ ICD-10-CM Code __________________________  

ICD-10-CM Code __________________________ ICD-10-CM Code __________________________  

Printed Name ____________________________  

Physician (M.D. or D.O.)/Psychologist (Ph.D.)/Physician Assistant/Certified Nurse Practitioner  

Signature ____________________________________________  

Physician (M.D. or D.O.)/Psychologist (Ph.D.)/Physician Assistant/Certified Nurse Practitioner  

Date ____________________________________________  

Printed Name ____________________________________________  

BISF Service Coordinator- verifying approved ICD-10 code  

Signature ____________________________________________  

BISF Service Coordinator- verifying approved ICD-10 code  

Date ____________________________________________  

Note to the Medical Professional Completing this Form:  
A confirmation of a qualifying Brain Injury ICD-10 code is required by the Human Services Department for all those receiving services from the BISF Program. Applicants, who do not have a confirmed and appropriate Brain Injury ICD-10 code, are not eligible to receive BISF services.  

In order for your patient to receive BISF services, the code(s) supplied must support a qualifying diagnosis for Traumatic Brain Injury (TBI) and/or other Acquired Brain Injuries, such as stroke, aneurysm/vascular lesions of the brain, brain tumor, anoxia, brain infections, lightning/electrical shock, exposure to toxic or chemical substances, and shaken baby syndrome.  

The BISF Program will determine if the code(s) supplied qualifies the individual for short-term services. Please fill out this form and return to Goodwill Industries of NM METRO Office at 5000 San Mateo NE, Albuquerque, NM 87109. Ph: 505-881-6401 Fax: 505-884-3157
Brain Injury Service Fund Service Coordination Agencies by County and Region

Metro Region: Goodwill Industries of NM
5000 San Mateo NE, Albuquerque, NM 87109
PH: 505-881-6401
Fax: 505-884-3157

Northwest Region: Goodwill Industries of NM
1820 E. Highway 66, Gallup, NM 87301
PH: 505-863-6374
Fax: 505-863-6199

Northeast Region: Goodwill Industries of NM
3060 Cerrillos Road, Santa Fe, NM 87507
PH: 505-216-3306
Fax: 505-884-3157

Southeast Region: Goodwill Industries of NM
2601 N. Main St., Roswell, NM 88201
PH: 575-622-4980
Fax: 575-622-5501

Southwest Region: Goodwill Industries of NM
2407 W. Picacho St., Las Cruces, NM 88007
PH: 505-323-5147
Fax: 505-884-3157
Brain Injury Services Fund
Program  (Effective 10/01/2015)
(Short-Term Services for People Living with Brain Injury)

What is the Brain Injury Services Fund (BISF) Program?
This program provides short-term services to individuals with a crisis need, who have been
diagnosed with a Brain Injury acquired through traumatic brain injury; shaken baby syndrome;
stroke; brain tumor; anoxia; aneurysms / vascular lesions; brain infections; lightning / electrical shock; or
exposure to toxic or chemical substances. The BISF Program provides three services: Service
Coordination, Life Skills Independence Coaching, and Crisis Interim Services. It is funded
from a $5 fee, added to New Mexico moving traffic violation tickets.

Who is eligible for the BISF Program?
Individuals, who are in crisis, are eligible to receive short-term services from the NM BISF
Program, if they have been diagnosed with a Brain Injury, which has been confirmed through
written documentation by a licensed physician or psychologist. Eligible individuals must be
residents of New Mexico. The BISF is the payer of last resort for individuals seeking
assistance to live more independently in their homes and communities. The BISF is not an
entitlement program, and not everyone living with a brain injury will qualify for services.

What services are available?
Service Coordination / Independence Coach Coordinators- Service Coordination is the
point of entry for those who wish to receive program services. Service Coordinators
are responsible for determining eligibility, assessing needs, identifying appropriate services, and
helping participants access needed services and resources.

As Independence Coach Coordinators, they may also provide Life Skills Coaching
assistance, unless a contracted and licensed entity is available to do so. Life Skills
Independence Coaching is customized to provide assistance in meeting the unique needs
of individuals living with a Brain Injury. Coaching services may include assistance with
relearning activities of daily living (ADLs); time management; home organization; financial
organization; dealing with personal relationships; anger management; the use of memory
prompts; and how to access social, recreational, education resources and employment.

Crisis Interim Services- Crisis Interim Services are provided to a person in crisis following an
initial event of brain injury, in the event of a worsening condition or to alleviate a new crisis.
Funds may be used to pay for home health care; homemaker services; respite care; outpatient
mental health; therapies; medically-related transportation and medications related to the brain
injury; physician co-pays; special equipment, communication/assistive devices, and durable
medical goods; professional life skills coaching / organizer services; once in a lifetime
housing assistance; environmental modifications; and retrofit of an automobile. Funding is
only available for services that are necessary due to an individual's brain injury. Funding is
allocated regionally and may or may not be available for all services at the time of request. All
requests for Crisis Interim Services must be processed through a BISF Service Coordinator.

How to Apply:
Please call the Service Coordination agency, listed to the right, which is nearest to your home,
to learn more about the program and to get assistance in applying for BISF Program services.

Important Points to Remember:
Funding is Allocated Regionally- and may or may not be available for all services at the
time of request.

To Inquire About Other Service Options- Please contact the NM Brain Injury Resource
Center. Persons with Brain Injury in need of long-term services should contact the Aging and
Disability Resource Center (800-432-2080) to be placed on the Central Registry for Brain
Injury.

(To be implemented 10/01/2015)
OTHER CONTACT INFORMATION FOR THE
BRAIN INJURY SERVICES FUND PROGRAM:

NM Brain Injury Resource Center  855-849-0921; 505-272-0411
UNM Center for Development and Disability
(Information/Referral; Peer Mentors; Educational Opportunities)
http://www.cdd.unm.edu/nmblrc/index.html
Email: nmbirc@salud.unm.edu

Brain Injury Program / BISF Manager: Linda Gillet, Ph.D.
Brain Injury Program
Exempt Services and Support Bureau (ESPB)
Medical Assistance Division (MAD)
Human Services Department (HSD)
Ark Plaza
PO Box 2348
2025 S. Pacheco
Santa Fe, New Mexico 87504
http://www.hsd.state.nm.us/LookingForAssistance/brain-injury.aspx
E-mail: LindaB.Gillet@state.nm.us
Phone: 505-827-7218
Fax: 505-827-7277

OTHER IMPORTANT BRAIN INJURY PHONE NUMBERS:

Brain Injury Advisory Council:  505-476-7328
http://www.nmbiac.com

Brain Injury Alliance of New Mexico:  505-292-7414
http://www.braininjurynm.org