

NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM

HUMAN SERVICES DEPARTMENT

Medical Assistance Division



APPLICATION

Short-Term Brain Injury Services

STEPS TO APPLY FOR BRAIN INJURY SERVICES THROUGH THE BRAIN INJURY SERVICES FUND (BISF) PROGRAM

1. Please see the Tip Sheet on page 11 to learn about the Brain Injury Services Fund (BISF) Program. To receive help, you must be a New Mexico resident and have a confirmed diagnosis of brain injury.
2. **Pages 1 – 3:** Fill in answers to the questions on *pages 1 and 2* and sign. Do NOT fill in *page 3*, "TO BE COMPLETED BY SERVICE COORDINATOR ONLY."
3. **Pages 4 and 5:** Fill in the "Release of Information", and sign.
4. **Pages 6 and 7:** Fill in page 6, "Assurances", and sign. Fill in and sign the "Residency Affidavit" on *page 7*, only if you are a NM resident.
5. **Pages 8 - 10:** On *page 8*, fill in your name and the name of the doctor or psychologist, who knows about your brain injury. Take these pages to the doctor or psychologist, who knows about your brain injury. Ask them to read *pages 8 - 10* and fill in *page 9*. They can give the form back to you to give to the Service Coordination Agency (SCA) you want to work with in your region. Or they can mail it or fax it to the SCA. (See *page 10* for the agencies in your region.) If you are approved, the SCA will help decide the services that will help. Be sure to sign all the pages you are asked to sign. This will help with the process.
6. **Submit your application:** Mail, fax or drop off all pages to your SCA. (See *page 10*). If you have questions, you may call the NM Brain Injury Resource Center at 1-844-366-2472.

A. GENERAL

Date:

1. Name (Last, First, Middle Initial)	2. Social Security Number	3. Date of Birth
4. Sex: Female Male	5. Marital Status: Married Single Divorced Widowed	
6. Ethnicity: Hispanic Caucasian Native American Asian African American Other (specify): _____		
7. Primary Language: English Spanish Navajo Other (specify): _____		
8. Veteran Status		
A. Are you a veteran of the US Armed Forces? Yes No (If yes, answer B and C.)		
B. If "Yes", please list the dates you served and give your veteran status. Or give the SCA a copy of your DD214.		
Dates of service: _____		
Veteran status: _____		
C. Do you have a documented service-connected disability? Yes No		

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 you got your Brain Injury.	

B. Explain why you want help from the Brain Injury Services Fund Program.	

C. How did you hear about the Brain Injury Services Fund Program?	

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

Phone number of person above, if not given in # 13, above: _____	
16. Emergency Contact Information	
Name: _____	
Address: _____	
Relationship: _____	
Phone Number (with area code): _____	
17. Signature of Applicant, Parent, or Legal Guardian	
_____	_____
Signature	Date

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DO NOT FILL SECTIONS ON THIS PAGE TO BE COMPLETED BY SERVICE COORDINATOR ONLY	
Service Coordination Agency	Date Referred
Service Coordinator	
ICD-10 Code (s) List codes here: <input type="checkbox"/> TBI <input type="checkbox"/> Other ABI	Date of Injury

<input type="checkbox"/> Applicant Qualifies / Approved	Date Approved
<input type="checkbox"/> Applicant Qualifies / Approval Pending Allocation	Date Allocation Opened
<input type="checkbox"/> Applicant Does Not Qualify / Denied (Appeal Procedures Mailed)	Date Denial Mailed
Service Coordination Staff Signature	
Start of Service Date	Inactivation Date
REFERRED FOR:	
<input type="checkbox"/> Fiscal Intermediary Agent Services	Date

If denied, state reason(s) below:



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RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Date:

Applicant's Name	Social Security Number	Date of Birth
Address		Phone Number (w/area code)
City, State, Zip Code		County

*"I, the undersigned, hereby give those listed in **Section A** the right to share some protected health information (PHI) about my Brain Injury. They can share it with the New Mexico Human Services Department (HSD) / Medical Assistance Division's **Brain Injury Services Fund (BISF) Program**. This allows them to give my PHI to the Service Coordination Agency (SCA) that I have checked in **Section B**. This SCA needs this to see if I qualify for the BISF Program. It also lets the SCA get me the help I need. I know that HSD and all of those involved in my care will need to know my PHI, so that I can get the help and services I need."*

*"I also allow the BISF Provider, noted in **Section B**, to have, use, and/or share the PHI. I may be referred to the Program's "Fiscal Intermediary Agent", or "FIA", to help me get services I need. The FIA also needs the PHI to pay for the services I need. So, I allow my BISF SCA to share my PHI with the FIA listed in **Section C**. I know that the PHI shared between BISF Service Providers has to do with my Brain Injury and the services I get through the BISF Program."*

*"The health provider's that I list in **Section A** will only share the information shown. All PHI that is shared for my services will stay private."*

Section A: Please check the records you wish to share. Also note the time period for any of these records. Or write, "All dates of service".

Please Check	Type of Information Required:	Enter Provider's/Physician's Name and Location (City/Address)	Service Date(s) To/From
<input type="checkbox"/>	Records (ICD -10 Code) Verifying Brain Injury Diagnosis		
<input type="checkbox"/>	Physician's Statement		
<input type="checkbox"/>	Supporting Report		
<input type="checkbox"/>	Other Diagnoses		
<input type="checkbox"/>	Neuropsychological Evaluation(s)		
<input type="checkbox"/>	Complete Medical Record		
<input type="checkbox"/>	Hospital Admission/Discharge Records		
<input type="checkbox"/>	Mental Health/Substance Abuse Records		
<input type="checkbox"/>	Other (Please specify)		

Section B: All BISF applications will go to the Service Coordination Agency you choose below. Check the Service Coordination Agency for the region where you live. (See map on page 10.)

Check One	Service Region	BISF Service Coordination Agency Authorized to Use or Disclose PHI	Address of Authorized Regional BISF Service Coordination Agency
	Metro	CNRAG (Care Network Resource Assistance Group)	315 Central Ave NW., Suite M, Albuquerque, NM 87102
	Metro	Los Amigos LLC	1601 Randolph Court, Suite 110-S, ABQ, NM 87106
	NE	Los Amigos LLC	1435 S. Saint Francis Dr., Suite 210, Santa Fe, NM 87505
	NW	CNRAG (Care Network Resource Assistance Group)	315 Central Ave. NW, Suite M, Albuquerque, NM 87102
	SE	CNRAG (Care Network Resource Assistance Group)	225 E. Idaho Ave., Suite 26, Las Cruces, NM 88005
	SW	CNRAG (Care Network Resource Assistance Group)	225 E. Idaho Ave., Suite 26, Las Cruces, NM 88005

Section C: Check the Statewide Fiscal Intermediary Agency if you wish to receive Home and Community Based Services.

This is the agency that pays for the services and goods you may get through the BISF Program. NOTE: The BISF Program does not recognize or allow payment for services through other agencies that claim to have a fiscal agent role. Staying in the BISF Program is not allowed for those whose Home and Community Based Services are covered through other payer sources. These could be State Medicaid programs, Medicare, private insurance, I.H.S, VA or any programs in which the individual is voluntarily enrolled.

Please Check	Service Region	BISF Fiscal Intermediary Agent Authorized to Receive or Use My PHI	Address of Authorized Regional BISF Fiscal Intermediary Agency
	Statewide	HelpNet LLC	PO Box 1090, Los Alamos, NM 87544

I know that I can look at the PHI that will be shared. I can also ask my SCA for a copy of this release any time. I can take back this permission at any time. To do so, I must tell the SCA in writing. This will not apply to what my BISF Service Providers have done or need to do to close my case and pay for services I have used. I also know that my PHI may not be protected by federal law. The doctors, BISF Providers and any of their employees who share my PHI will not be blamed or held at fault for sharing my PHI. I know that it allows everyone to do their jobs to meet my needs.

This release is valid from _____ until _____ <div style="text-align: center; margin-top: 5px;">Date</div>	_____ <div style="text-align: center; margin-top: 5px;">Date</div>
<i>(If end date is not specified, this will expire 12 months from the date above.)</i>	

Name of Applicant

Name of Parent or Legal Guardian (if applicable)

Signature of Applicant, Parent, or Legal Guardian

Date

If signed by Legal Guardian, describe the legal authority that allows you to act on behalf of the applicant. Please add legal proof, if you are the Legal Guardian or if you hold Power of Attorney for health-care decisions.

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



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Assurances

“Assurances” mean I give my word of honor. I, (print name) _____ agree to give true and complete information to see if I or my family member qualify to get help from the BISF Program. I know that legal action may be taken to get back amounts that were paid for any services for which I did not truly qualify. I also know that I or anyone who helps me give information that is not true, so I can get these services, can be charged with crimes. This means I must be honest in all the information I give that helps me get services. This is true not only on this application, but for the entire time I am in the BISF Program. I understand all of the questions that have been asked in filling out this application, and I agree that the answers I have given are true and complete.

Signature of Applicant or Representative

Date

Signature of Guardian
(Required if person applying is under 18 years of age or if he/she has a legal guardian.)

Date



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Residency Affidavit

I, (print name) _____
reside _____
am being honest that I live in New Mexico. This is what “Residency Affidavit” means. I know that if I am not honest about this, I could lose services from the New Mexico Brain Injury Services Fund Program at any time.

Signature of Applicant, Parent, or Legal Guardian

Date

If not signed by the person applying for services (that is the “Applicant”), what is the relationship of the person signing to the Applicant? _____

What is the reason that the Applicant can’t sign?: _____

Note to Applicant: The letter on the page 8 is addressed to the Medical Provider who will be providing a code that says you have a brain injury. It gives the doctor or psychologist some information about the BISF Program and asks them to give the Program a code that will help you get the services you need.

The form on page 9 is also for your Medical Provider. This is where the doctor or psychologist will give codes that may allow you to receive help from the BISF Program.

If you have any questions about the letter on page 8, the form on page 9, or about where the form needs to go (page 10), you may call the HSD BISF Program Manager at 505-827-7218.



NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM

HUMAN SERVICES DEPARTMENT
Medical Assistance Division

Letter to Medical Provider
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** with (fill in name of Service Coordination Agency) _____, 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 the Service Coordination Agency noted above, using the contact information noted on page 10. 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,

A handwritten signature in blue ink, appearing to read "Linda Gillet".

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

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: _____

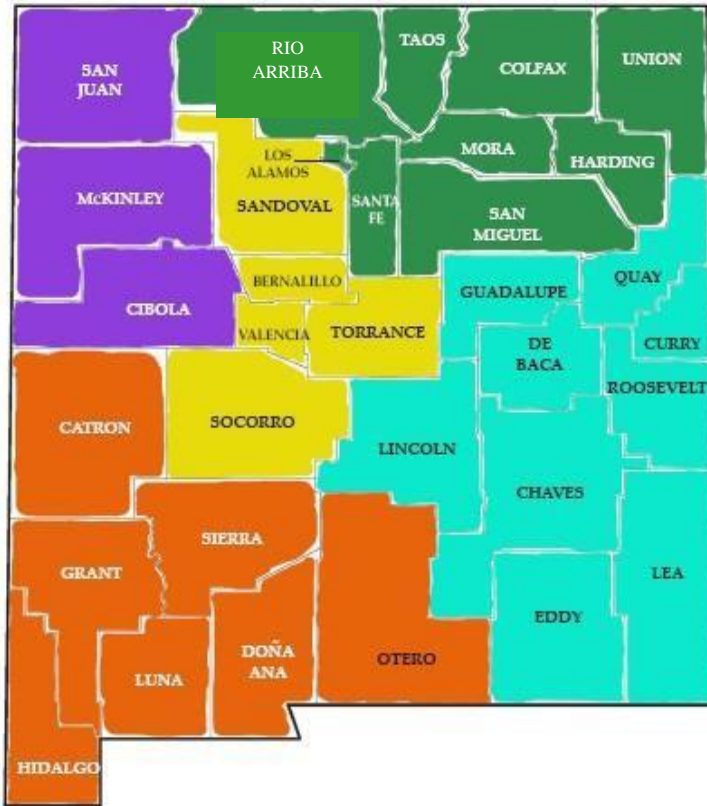
Note to the Medical Professional Completing this Form:

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 the Service Coordination Agency for the region in which your patient resides, as noted on Page 10.

Brain Injury Service Fund Service Coordination Agencies



METRO	<p><u>Care Network Resource Assistance Group (CNRAG), Inc.</u> 315 Central Ave. NW, Suite M, Albuquerque, NM 87102 PH: 505-936-5807 or 575-526-9084 Website: http://cnragusa.com/bisfservicecoordination.html</p>	FAX: 888-838-7086
METRO	<p><u>Los Amigos LLC</u> 1601 Randolph Court, Suite 110-S, Albuquerque, NM 87109 PH: 505-204-6035 Website: https://www.losamigosnm.com/</p>	FAX: 505-474-2804
NORTHEAST	<p><u>Los Amigos LLC</u> 1435 St. Francis Dr., Santa Fe, NM 87505 PH: 505-204-6035</p>	FAX: 505-474-2804
NORTHWEST	<p><u>Care Network Resource Assistance Group (CNRAG), Inc.</u> 315 Central Ave. NW, Suite M, Albuquerque, NM 87102 PH: 505-936-5807 or 575-526-9084</p>	FAX: 888-838-7086
SOUTHEAST	<p><u>Care Network Resource Assistance Group (CNRAG), Inc.</u> 225 E. Idaho, Las Cruces, NM 88005 PH: 505-936-5807 or 575-526-9084</p>	FAX: 888-838-7086
SOUTHWEST	<p><u>Care Network Resource Assistance Group (CNRAG), Inc.</u> 225 E. Idaho, Las Cruces, NM 88005 PH: 505-936-5807 or 575-526-9084</p>	FAX: 888-838-7086

Brain Injury Services Fund (BISF) Program

(Short-Term Services for People Who Live with Brain Injury)



TIP SHEET

Revised September 2019

What is the Brain Injury Services Fund (BISF) Program?

The BISF Program helps people with brain injury to live more independently in their homes and communities. The program provides statewide, short-term aid to people with brain injury at times of crisis when there is no other way to pay for the help that is needed. Those who qualify get services without any cost to them. This program is administered by the New Mexico Human Services Department.

Who can you get help from the BISF Program?

To be eligible, applicants must:

- Be a New Mexico resident
- Have a diagnosis of brain injury from a doctor, doctor's assistant, nurse practitioner, or psychologist. The types of brain injury that qualify a person include traumatic brain injury, stroke, aneurysm, vascular lesions, brain tumor or anoxia. They also include damage from brain infections, lightning strike, electrical shock, or exposure to toxic or chemical substances
- Have a crisis caused by their brain injury

The program can help those without Medicaid or health insurance, or those whose health insurance or other benefits cannot pay for the services they need.

What services are available?

Service Coordination – The Service Coordinator helps with the eligibility process and assesses person's needs. They help program participants find services and resources that will resolve the crisis, helping the person live more independently at home and as part of the community.

Home and Community Based Services (HCBS)- Services available include home health care, homemaker services, or respite care, treatment-related transportation, special equipment, communication or assistive devices, durable medical goods, professional life skills coaching, and organizer service. The program can also cover copays for outpatient mental health, therapies (traditional and alternative), doctor visits and medications related to the brain injury. The program also assists with emergency housing needs. Funds are for help that is needed due to the brain injury and may or may not be available for all services at the time of request. The BISF Program services are intended to help end the person's crisis, and they stop when the crisis is resolved.

How to Apply:

Please call the Service Coordination Agency (SCA) in the region where you live. These agencies are listed to the right. The SCA can help you learn more about the Program and how to apply. There is a choice of SCAs in the Metro region.

For Information, Referrals and Resources:

Call the NM Brain Injury Resource Center (NMBIRC) at ARCA:
1-844-3NM-BIRC or 1-844-366-2472

Visit the NMBIRC Website:

<https://www.arcaopeningdoors.org/services/new-mexico-brain-injury-resource-center/>

Visit the NMBIRC Community Center / Clubhouse:

1504 4th St NW
Albuquerque, NM 87102

BISF SERVICE COORDINATION AGENCIES:

METRO REGION

CNRAG, Inc.
315 Central Ave. NW, Suite M
Albuquerque, NM 87105
575-936-5807
575-526-9084

or

Los Amigos LLC
1601 Randolph Ct., #110-S
Albuquerque, NM 87106
505-204-6035

NORTHEAST REGION

Los Amigos LLC
1435 St. Francis, Ste 210
Santa Fe, NM 87505
505-204-6035

NORTHWEST REGION

CNRAG, Inc.
315 Central Ave. NW, Suite M
Albuquerque, NM 87102
575-936-5807
575-526-9084

SOUTHEAST REGION

CNRAG, Inc.
503 S. Kansas
Roswell, NM 88203
575-936-5807
575-526-9084

SOUTHWEST REGION

CNRAG, Inc.
225 E. Idaho Ave, Ste 26
Las Cruces, NM 88005
575-936-5807
575-526-9084



**OTHER CONTACT INFORMATION FOR THE
BRAIN INJURY SERVICES FUND PROGRAM:**

**NM Brain Injury Resource Center
ARCA / Brain Injury Division
1503 4th Street NW
Albuquerque, NM 87102
Tel: 1-844-3NM-BIRC; 1-844-366-2472
Email: nmbirc@arcaspirit.org
Director: Michael Langford, CBIS
Website: www.nmbirc.org**

**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)
PO Box 2348
Santa Fe, NM 87507-2348
<https://www.hsd.state.nm.us/LookingForAssistance/brain-injury.aspx>
E-mail: LindaB.Gillet@state.nm.us
Phone: 505-827-7218**

For other helpful community resources, please visit:
<http://nmbirc.org/helpful-links/> or click here: [NMBIRC](http://nmbirc.org)