Application for Services

Please complete and mail, fax, or email to:
Brain Injury Connections of the Shenandoah Valley
755 Martin Luther King Jr Way, MSC 9020
Harrisonburg, VA 22801
Phone: (540) 568-8923
Fax: (540) 568-8864
info@bicsv.org

Brain Injury Connections of the Shenandoah Valley

Please provide the following information for the person needing the services:

Name:_____ **Home Phone: (_____) _____**

Address:_____ **Other Phone: (_____) _____**

Apartment number: _____ **Email:** _____

City: _____ **Date of Birth:** _____

State: _____ **Zip Code:** _____ **Social Security #:** _____ - _____ - _____

City/County of Residence: _____ **Gender:** ____ **Male** _____ **Female**

Do you have a legal representative? ____ **No** ____ **Yes If yes, please provide name and relationship:**

Name: _____ **Relationship:** _____
Please attach/submit legal representation documentation.

What is the <u>best method</u> for contacting the applicant and/or legal representative(s) or caregiver?

Name: _____ **Contact Information:** _____

Name: _____ **Contact Information:** _____

Brain Injury Information:

Date of Injury: _____

Cause of Injury: _____

_____

Briefly describe the issues you may be having <u>as a result of your brain injury</u>, including what help you may need:

Which of the following evaluations have you had completed? (Please provide a copy and name of the provider):

- ☐ Neurological
- ☐ Neuropsychological
- ☐ Psychological / Psychiatric
- ☐ Therapy (Physical, Occupational, Speech)
- ☐ Other

If attending School, do you (client) have an:

- ☐ IEP
- ☐ 504 Plan

If you do please provide a copy of the plan.

How did you hear about us?

- ☐ Community Agency
- ☐ Brochure
- ☐ Department for Aging and Rehabilitative Services (DARS)
- ☐ Word of mouth from friend or family member
- Community event or presentation
- ☐ Internet / Website
- ☐ Brain Injury Assoc. of Virginia (BIAV)
- ☐ Physician
- ☐ Other _____

Referral formation:

Name of person completing the application: _____

Company /Organization: _____

Street Address: _____Apt. No._____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ - _____ Email: _____

Relationship to applicant: _____Signature:_____

☐ I am the applicant and I would like services from Brain Injury Connections of the Shenandoah Valley.

☐ I am applying on behalf of another individual as his/her legal representative. The individual (applicant) is aware that this application is being submitted on his/her behalf and desires services.

Circle One - <u>Applicant</u> or <u>Legal Representative</u> of Person Applying for Services (Please attach/ submit legal representation documentation.)

Signature:_____

Printed Name: _____ Date:_____

*** Note: If you are a provider working for another community agency or organization and submitting this application on behalf of another individual, the individual must sign above as applicant (unless you are a legal representative), please obtain consent and include any relevant medical or other documentation with this application. You may fax records to (540) 568-8864.*