SDS Use Only: LOG # TABI 24-_____

Alaska Department of Health

Senior and Disabilities Services

FY24 Traumatic & Acquired Brain Injury Mini-Grant Application

Applicant Name:	Date of Birth:	Age:

Mailing Address:	City:	State:	Zip Code:

Phone:	Email:

Have you applied for a TABI mini-grant before?	Yes ○	No ○
Have you received a TABI mini-grant before?	Yes ○	No ○
Currently receiving Medicaid ☐ Medicare ☐ ?	Yes ○	No ○
Are you Medicaid or Medicare eligible?	Yes ○	No ○
Do you have private insurance?	Yes ○	No ○
If yes, has this request been denied by insurance?	Yes ○	No ○

Amount Requested:

Describe equipment and/or services requested: *(Attach supporting documentation, e.g., two estimates from separate vendors or prescription from a licensed health care professional. Include cost of shipping and enough detail to facilitate the purchase if awarded the mini-grant.*

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Describe the essential need which the equipment/services will address. Provide additional documented evidence of need, if available. List all other resources that were explored in addition to the TABI mini-grant.

Describe how the equipment/services will increase independent functioning and integration in the community. What outcome is expected if funding is received? What outcome will take place if funding is not received?

Person Completing form:

Relationship to Applicant:

Phone:

Email:

TABI Provider Agency:

TABI Provider Agency Contact:

Email:

Phone:

SDS Use: Amount Approved: _____

Program Manager: _____ Signature: _____ Date:_____

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Additional Supporting Documentation

STATEMENT OF INJURY AND CIRCUMSTANCES

Please provide a written explanation, including the date and circumstances, of your injury:

GUARDIAN INFORMATION

If applicable, please provide information on your court-appointed conservator or guardian.

Name:

Physical Address:

Mailing Address:

Email:

Phone:

Preferred Contact: Mail ☐ Phone ☐ Email ☐

Guardianship Type:

☐ Public Guardian (OPA)

☐ Representative payee

☐ Full (legal guardian

☐ Conservatorship

☐ Power of Attorney (POA)

☐ Other _____

Attach a copy of court documents establishing guardianship if applicable

State of Alaska • Department of Health • Division of Senior and Disabilities

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

Medicaid # _____ Record # or Other ID: _____ Date of Birth: _____

Other Names Under Which Records Might Be Filed: _____

Person/Organization Releasing Information: Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider or education provider, that has provided payment, treatment or services to me or on my behalf and _____ (name of ICAP Respondent or Care Coordinator may be inserted. ***Note** if text box is not used insert "N/A"; if text box is used, do not use this form to request any records or information except from the person or agency named in the text box)

Person/Organization Receiving Information: (*include address if needed*) Alaska Department of Health and Social Services, Senior & Disabilities Services and _____ (name of Care Coordinator or PCS Agency representative or ADRC or DDRC representative may be inserted).

Description of Information To Be Released: *(If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description)* **health care provider notes (excluding psychotherapy notes, as defined by HIPAA), history & physical records, admission notes, discharge summaries, discharge plans, notes from clinic visits, laboratory records and reports, imaging and radiology records and reports, swallow studies, inpatient and outpatient records, physical therapy records, occupational therapy records, respiratory therapy records, dialysis records, chemotherapy records, educational records and assessments, and the personal knowledge of respondents or agencies named in my ICAP application if applicable. Note* release records that are current within the previous 12 months from the date of the request.** *The purpose of the release of this information is: to obtain health care records and financial information needed to determine eligibility to receive or continue to receive services and other benefits through programs managed by the State*

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event. _____

_____ _____

Signature of Client or Legal Representative (Or Witness if signature is by mark) Date

_____ _____

Printed Name of Legal Representative or Witness Description of Legal Representative's Authority

NOTE: This authorization was revoked on: _____ *(Date)(see attached revocation)*

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

UNI-16 (Rev.7/23/19), HIPAA Compliant (ADA 1/8/2020)

RECIPIENT INFORMATION: If the identifying information released pertains to the diagnosis, treatment, or referral for treatment for a substance abuse disorder, the confidentiality of the information is protected by federal law (42 CFR Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

INSTRUCTIONS:

The elements of this form described below (1-5) and marked with an asterisk (*) MUST BE COMPLETED. There are NO exceptions. Incomplete authorization forms are invalid and WILL NOT BE PROCESSED!

1. **Client Information ***: Enter the Name, Medicaid #, Case # or Client ID, if applicable, and Date of Birth of the individual whose information (PHI) is being released or requested. At least one identifier other than name must be present – e.g. Medicaid # or DOB or Case # or Client ID

2. **Organization Releasing and Receiving Information ***: The information for the **"Organization Releasing"** is pre-filled but it also provides for the insertion of an individual's name in the event that the request needs that level of individualization; **if the text box is not needed, insert "N/A" in the text box**. ***If a name is placed in the "Organization Releasing" text box it may ONLY be used for that particular person or organization. It should not be sent to request medical records.** The information for the **"Organization Receiving Information"** is pre-filled except for the name of the Care Coordinator or PCS Agency representative; be sure to enter the name of the person or the agency in addition to SDS that is receiving information in this text box.

3. **Description of Information to be Released ***: This information is pre-filled.

4. **Expiration Date/Event ***: Enter a date or event that is reasonable and acceptable to the client or client's representative. For instance, "*One year from the date of this authorization*" is generally accepted as a reasonable expiration date. ***If your client consents it is also permissible to insert "when I am no longer receiving benefits from the state"**

5. **Signatures & Dates ***: The individual whose PHI is being released or requested must sign and date the form. If the individual is a minor, or is otherwise not able to sign the form, the individual's authorized representative or witness must sign and date it. If an authorized representative is signing the form on behalf of the client, the representative's "legal authority" to act on the part of the individual must be verified first and then described in the appropriate space. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released or requested.

6. **Revocation Date**: The revocation date on this form does NOT need to be completed UNLESS the individual has revoked this authorization using State of Alaska Department of Health and Social Services form 06-5872 Revocation of Authorization found on the SDS Approved Forms web page. If revoked, a copy of the revocation should be attached to this form & the date of revocation noted on the front of this form.

7. **ALL authorization forms MUST be retained for SIX (6) YEARS from the date of signature**. This form should be stored in the client file, if one is maintained. Some programs have procedures requiring the form, or a copy of the form be retained solely or additionally by the Division Privacy Official. Please refer to the appropriate Division or Program specific procedures or inquire with your Division Privacy Official regarding any additional retention requirements of authorization forms.

8. If requested, provide a copy of this authorization to the client or client's representative.

QUESTIONS?
Contact the SDS Front Desk at (907) 269-3666 with any concerns you may have.