

Please complete and return to:
Arkansas Department of Health TBI Program
4815 W Markham, Slot H10
Little Rock, AR 72205-3867

This document may be obtained in electronic format
Email: loretta.alexander@arkansas.gov

ARKANSAS TRAUMATIC BRAIN INJURY PROVIDER RESOURCE ASSESSMENT

Date _____

Name of Organization _____

CEO/Director _____ Contact Person _____

Mailing Address _____

(Include City, County, State and Zip)

Street Address (if different from above)

(Include City, County, State and Zip)

Organization type: ___ Public ___ Private ___ For Profit ___ Not for Profit _____

Phone _____ Fax _____

E-mail _____ Website URL _____

What year was your business started? _____

Section A.

1. Does your organization provide services for individuals or families who have experienced traumatic brain injury (TBI)?

___ NO

___ YES

2. Through which agency is your organization accredited?

___ Commission on Accreditation of Rehabilitation Facilities

___ Joint Commission on Accreditation of Hospital Organizations

___ American College of Surgeons-Trauma Center: level _____

___ None

___ Other (please specify) _____

3. In which county(ies) in Arkansas does your organization offer services for individuals with TBI? _____

4. Estimate what percentage of your payment from clients comes from each of the following sources:

___ % Medicaid

___ % Medicare

___ % Private Insurance

___ %Other (please specify source) _____

5. What was the **total number of individuals served** _____ by your organization from _____ to _____? (Specify own dates)

6. What was the total number of individuals **who had a primary diagnosis of TBI** served by your organization _____ using the above timeframe.

7. Indicate how referrals for services related to TBI are received in your program. (*Check all that apply*)

- resource line (e.g. 211 system, 1-800#)
- voluntary registry
- reporting regulation/mandated registry
- from acute care hospital
- from rehabilitation facility
- from judicial system
- from the State's Office of Vocational Rehabilitation
- from other State agencies, (not VR)
- from Protection & Advocacy
- referral from BIA or other non-profit organization
- professional Practitioners (counselors, physicians, etc)
- self Referral
- other _____
- no system identified

8. Using the following categories, indicate the total number of individuals with TBI served by your organization from _____ to _____. (Specify own dates)

- RACE: African American
 Asian
 Hispanic
 America Indian/Alaska Native (List tribal affiliation if available)

 Caucasian
 Other (*please specify*) _____

GENDER: Female Male

9. How soon after injuries are people typically referred for services?

- Within 30 days
- 1-6 Months
- 7-12 Months
- 1-3 Years
- 4-6 Years
- 6 Years or more

10. Does your organization have designated staff specifically assigned to work on issues related to TBI?

- NO
- YES, If "Yes", please indicate all issues that are addressed. (*Check all that apply*)
 - Alcohol/drug addiction
 - Crisis situations
 - Mental health counseling (individual and family)
 - Family support

- Employment
- Housing
- Transportation
- Education
- Assistive technology
- Other (*please specify*) _____

11. Identify the total number of staff in your organization. _____
12. Identify the total number of staff in your organization who work primarily with individuals with TBI more than 50% of time. _____
13. Estimate the number of hours spent per year in continuing education and training specific to TBI by staff who serve individuals with TBI (e.g., conferences, workshops, etc.).

_____ Hours (*per year*) of education/training specific to TBI

14. Does your agency offer educational and/or training programs on TBI?
- NO
- YES If "Yes", for which groups are education/training available? (*Check all that apply*)
- Individuals with TBI
 - Families/significant others
 - Own staff
 - TBI Statewide Advisory Board/Council
 - Health professionals/rehabilitation providers
 - Law enforcement/criminal justice
 - Educators/teachers
 - Other (*please specify*) _____

If "Yes", what type of training is provided or funded? (Check all that apply)

- | | | |
|-------------------------------|----------------------------------|---|
| <input type="checkbox"/> Fund | <input type="checkbox"/> Provide | <input type="checkbox"/> Orientation of new employees |
| <input type="checkbox"/> Fund | <input type="checkbox"/> Provide | <input type="checkbox"/> In-services |
| <input type="checkbox"/> Fund | <input type="checkbox"/> Provide | <input type="checkbox"/> Conferences |
| <input type="checkbox"/> Fund | <input type="checkbox"/> Provide | <input type="checkbox"/> Consulting |
| <input type="checkbox"/> Fund | <input type="checkbox"/> Provide | <input type="checkbox"/> Other Professional Development |
| <input type="checkbox"/> Fund | <input type="checkbox"/> Provide | <input type="checkbox"/> TBI Statewide Advisory Board |
| <input type="checkbox"/> Fund | <input type="checkbox"/> Provide | <input type="checkbox"/> Other (Please specific) _____ |

Section B. *The following section concerns services that your organization provides.*

15. Does your organization have programs *specifically developed* for historically under-served populations (e.g., children & youth, people 65+, American Indians, Alaska Natives, Hispanics, African Americans, and Asians)?

_____ NO _____ YES

16. Does your organization provide direct services (e.g., treatment, therapy, transportation, housing, etc.) for individuals with TBI?

___ NO _____ YES

17. Does your organization engage in Prevention Activities?

- ___ NO
___ YES If "Yes", which services does it provide? (Check all that apply)
___ Primary prevention of intentional injuries (*Shaken Baby Syndrome, violence*)
___ Primary prevention of unintentional injuries (*falls, occupant protection*)
___ Secondary prevention (*of disabling conditions*)
___ Other (*please specify*) _____

18. Does your organization provide Acute Medical Services?

- ___ NO
___ YES If "Yes", which services does it provide? (Check all that apply)
___ Acute medical care
___ Discharge planning/service coordination
___ Emergency medical care
___ Family education, information and training
___ Family mentoring
___ Pre-hospital transport and treatment
___ Referral to subspecialties
___ Screening, identification and provision of discharge protocols at all levels of TBI (*mild, moderate, severe*)
___ Substance abuse screening
___ Trauma systems
___ Other (*please specify*) _____

19. Does your organization provide Education Services?

- ___ NO
___ YES If "Yes", which services are provided? (Check all that apply)
___ Advocacy (*Family/Child*)
___ Charter/private school
___ Early intervention/preschool
___ Education (*Kindergarten - 12th grade*)
___ Health related services (*i.e., OT, PT, Speech, etc.,*)
___ Higher education
___ Special education (*including all services outlined in IDEA*)
___ Transitional services
___ Other (*please specify*) _____

20. Does your organization provide Employment Services?

- ___ NO
___ YES If "Yes", which services does it provide? (Check all that apply.)
___ Advocacy (*self-family*)
___ Assistive technology
___ Career counseling/guidance
___ Job accommodations
___ Job coaching
___ Job development
___ Job placement
___ Pre-vocational services

- Special skills training (*computer, data processing*)
- Supported employment
- Vocational evaluation
- Work adjustment
- Work support
- Other (*please specify*) _____

21. Does your organization fund or provide Rehabilitation Services?

- NO
- YES If "Yes", please check which services it provides and the settings that are applicable? (*Check all that apply*)

	Fund	Provide	Under age 18	Over age 18	In-patient	Out patient	Day treatment	Community re-entry	Residential	Skilled Nursing	Other
Acute Medical Care											
Acute Rehabilitation											
Self Advocacy Training											
Assistive Technology											
Case Management											
Cognitive Therapy											
Community Agency/Referral											
Crisis Care											
Discharge Planning											
Driver Education											
Education/Special Education*											
Emergency Medical Care											
Family Education Training or Counseling											
Independent Living Skills											
Neurobehavioral Treatment											
Neuropsychology											
Nursing											
Occupational Therapy											
Orthodontics Prosthetics											
Physical Therapy											
Post Acute Rehabilitation											
Prevention Programs											
Pre-Vocational Services											
Psychiatry											
Psychology											
Social Work											
Speech/Language Therapy											

Substance Abuse Evaluation & Treatment											
Swallowing											
Therapeutic Recreation											
Trauma Systems											
Vocational Services											
Other											
	Fund	Provide	Under age 18	Over age 18	In-patient	Out patient	Day treatment	Community re-entry	Residential	Skilled Nursing	Other

22. Does your agency **fund** Long-Term Community Support services?

NO

YES If "Yes", which services does it fund? (*Check all that apply.*)

- | | |
|---|--|
| <input type="checkbox"/> Advocacy (self and community) | <input type="checkbox"/> Information/Resources |
| <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Case Management/Service Coordination | <input type="checkbox"/> Mental Health Services |
| <input type="checkbox"/> Chronic Neurobehavioral Treatment | <input type="checkbox"/> Nursing Care |
| <input type="checkbox"/> Clubhouse | <input type="checkbox"/> Peer Support |
| <input type="checkbox"/> Coma Care | <input type="checkbox"/> Personal Assistance/Attendant Services |
| <input type="checkbox"/> Day Program | <input type="checkbox"/> Primary Care Medical Services |
| <input type="checkbox"/> Durable Medical Equipment/Supplies | <input type="checkbox"/> Recreation/Social Programs |
| <input type="checkbox"/> Family Support, Education & Training | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Home Care/Home Support | <input type="checkbox"/> Skilled Nursing Care |
| <input type="checkbox"/> Housing (<i>Assessible/Affordable</i>) | <input type="checkbox"/> Substance Abuse Treatment |
| <input type="checkbox"/> Housing (<i>Modification</i>) | <input type="checkbox"/> Transitional Living Services |
| <input type="checkbox"/> Housing (<i>Supervised/Supported</i>) | <input type="checkbox"/> Transportation (Taxi Voucher, Medicaid) |
| <input type="checkbox"/> Independent Living Services | <input type="checkbox"/> Other _____ |

23. Please indicate by age group how many individuals with TBI received the following services from January 1, 2007 to December 31, 2007 _____.

	Infants (0-3)		Children (4-12)		Adolescents (13-17)		Adults (18-65)		Older Adults (65+)	
	Applied	Rec'd	Applied	Rec'd	Applied	Rec'd	Applied	Rec'd	Applied	Rec'd
Prevention										
Acute Medical										
Rehabilitation										
Education										
Employment										
Legal										
Long Term Community Supports										
Other										

24. Does your organization provide financial resources for individuals with TBI?

NO

YES, If "Yes", in what areas is financial assistance available? (*Check all that apply*)

- Shelter costs (*food, mortgage, rent, utilities, etc.*)
- Assistive technology
- Home Care/Home support
- Personal attendant services
- Medical equipment/supplies
- Respite care
- Transportation
- Other (*please specify*) _____

Section C. This section asks about needs or gaps in services as they relate to TBI.

25. Does a representative from your organization participate on the TBI Advisory Board or Task Force? NO YES

26. Is there TBI representation on any of your organization's task forces or advisory boards?
 NO
 YES, If "Yes", please describe _____
 Not applicable (*our organization does not have task forces/advisory boards*)

27. Does your organization have any formal inter-agency agreements with another agency or organization that serves individuals with traumatic brain injury?

NO
 YES If "Yes", please list organizations. _____

28. Are there gaps in TBI related services in your organization? If "Yes", please describe.

29. Are there existing TBI services that need to be expanded in your organization? If "Yes", please describe.

30. Are there other significant gaps in TBI services our State?

REMINDER: PLEASE ATTACH COPY OF ANY RELEVANT PRINTED INFORMATION ABOUT YOUR ORGANIZATION