# NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM

## Health Care Authority

Medical Assistance Division

HEALTH CARE AUTHORITY

## APPLICATION

***Short-Term Brain Injury Services***

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

IMPORTANT: Providing proof of citizenship, immigration status or a Social Security Number is not required to access BISF. All information provided is confidential. BISF does not create immigration consequences for those who participate.

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, not qualify for full Medicaid, 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",. 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 mail 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 (optional)** | **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 **Do you receive full Medicaid Benefits?** ☐ Yes ☐ No
(To qualify for the New Mexico Brain Injury Services Fund Program, you must be a resident of the State of NM and not qualify for full Medicaid benefits.)

**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 the type of Brain Injury and any information on when, where, and how you got your Brain Injury.

_____

_____

_____

B. What is your goal in accessing services through 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

# NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM

**Health Care Authority**

Medical Assistance Division

| DO NOT FILL SECTIONS ON THIS PAGE<br>TO BE COMPLETED BY SERVICE COORDINATOR ONLY | |
|---|---|
| **Service Coordination Agency** | **Date Referred** |
| **Service Coordinator** | |
| **ICD-10 Code (s)** ☐**TBI** ☐**Other ABI**<br>**List codes here:** | **Date of Injury** |

| | |
|---|---|
| ☐ **Applicant Qualifies / Approved** | **Date Approved** |
| ☐ **Applicant Qualifies / Approval Pending Allocation** | **Date Allocation Opened** |
| ☐ **Applicant Does Not Qualify / Denied**<br>(Appeal Procedures Mailed) | **Date Denial Mailed** |
| **Service Coordination Staff Signature** | |
| **Start of Service Date** | **Inactivation Date** |
| **REFERRED FOR:** | |
| ☐ **Fiscal Intermediary Agent Services** | **Date** |

**If denied, state reason(s) below:**

HEALTH CARE AUTHORITY

# NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM
## Health Care Authority
Medical Assistance Division

## RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

**Date:**

| **Applicant's Name** | **Social Security Number** (optional) | **Date of Birth** |
|---|---|---|
| **Address** | | **Phone Number** |
| **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 Health Care Authority (HCA) / 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 HCA 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. Please fill in exactly those records you wish to share **(Section A). In Sections B and C,** you will mark to whom they can go. Also note the time period for any of these records. Or write, "All dates of service". All PHI that is shared for my services will stay private.

**Section A: Check the records you wish to share**

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

**Section B: All BISF applications will go through 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) | PO Box 1680 Fairacres, NM 88033 |
| ☐ | Metro | Los Amigos LLC | 1601 Randolph Rd SE Suite 110S Albuquerque NM 87106 |
| ☐ | NE | Los Amigos LLC | 6533 Valentine Way Santa Fe NM 87507 |
| ☐ | NW | CNRAG (Care Network Resource Assistance Group) | PO Box 1680 Fairacres, NM 88033 |
| ☐ | SE | CNRAG (Care Network Resource Assistance Group) | PO Box 1680 Fairacres, NM 88033 |
| ☐ | SW | CNRAG (Care Network Resource Assistance Group) | PO Box 1680 Fairacres, NM 88033 |

**Section C: Check the Statewide Fiscal Intermediary Agency.** 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. Those could be "Community Support Agencies" or state Medicaid programs.

| 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 anytime. 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 _____

Date Date

*(If end date is not specified, this will expire 12 months from the date above.)*

_____ _____

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
HCA/ Medical Assistance Division / ESPB
PO Box 2348
Santa Fe, NM 87504-23482
BISF.HCA@hca.nm.gov


# NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM
## Health Care Authority
### Medical Assistance Division

## *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 the 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 Date
(Required if person applying is under 18 years of age or if he/she has a legal guardian.)


# NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM
## Health Care Authority
### Medical Assistance Division

## *Residency Affidavit*

I, (print name) _____

confirm 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 email the HCA BISF Program Coordinator at BISF.HCA@hca.nm.gov .

# NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM

## Health Care Authority

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 imminent 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 email **BISF.HCA@hca.nm.gov**.

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,

Crystal M. Cantu

Crystal Cantu, CBIS
Brain Injury Service Fund Program Coordinator
Medical Assistance Division
Health Care Authority

HEALTH CARE AUTHORITY

# 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) _____

Date of Birth 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

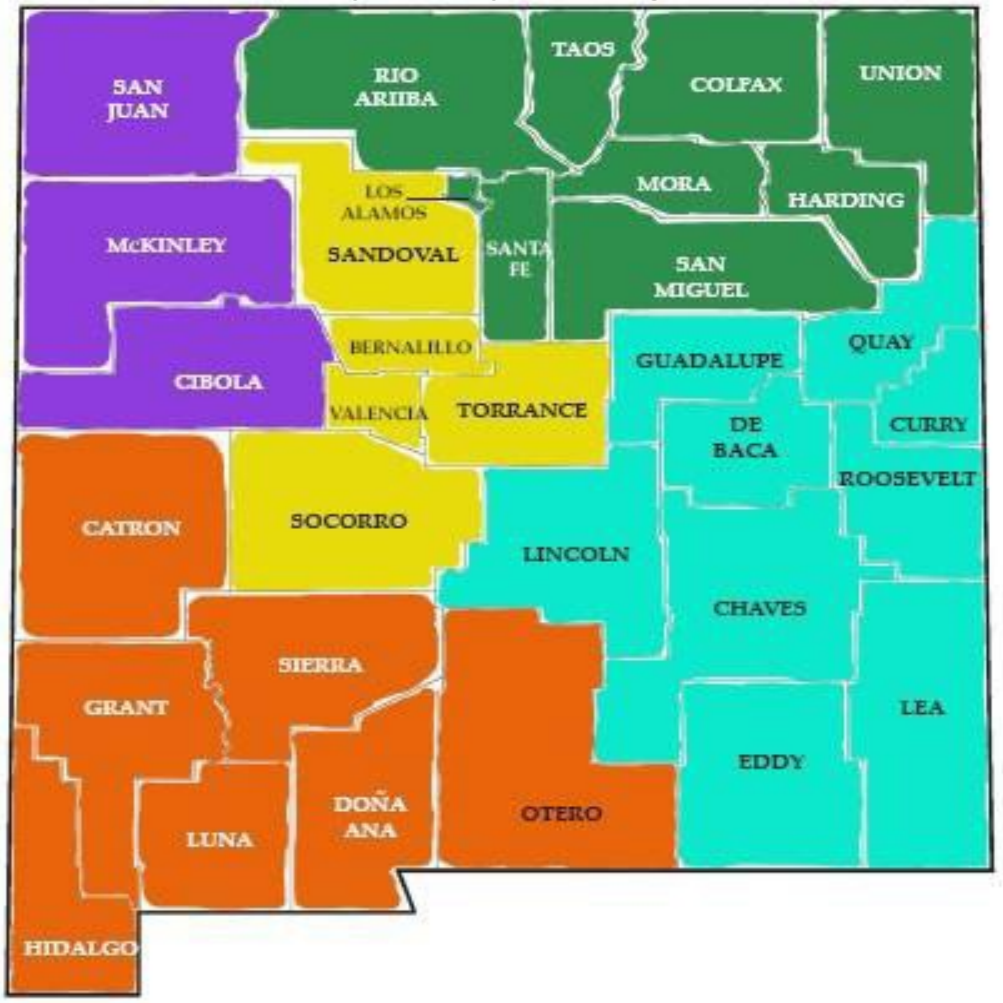
Date: _____

**Note to the Medical Professional Completing this Form:**
A confirmation of a qualifying Brain Injury ICD-10 code is required by the Health Care Authority 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 but not limited to 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 by County and Region




| | | |
|---|---|---|
| **METRO** | Care Network Resource Assistance Group (CNRAG), Inc.<br>PO Box 1680 Fairacres, NM 88033<br>PH: 505-936-5807 or 575-526-9084 | FAX: 877-702-8014 |
| **METRO** | Los Amigos LLC<br>1601 Randolph Rd SE Suite 110S, Albuquerque NM 87106<br>PH: 505-204-6035 | FAX: 505-474-2804 |
| **NORTHEAST** | Los Amigos<br>6533 Valentine Way, Santa Fe NM 87507<br>PH: 505-204-6035 | FAX: 505-474-2804 |
| **NORTHWEST** | Care Network Resource Assistance Group (CNRAG), Inc.<br>PO Box 1680 Fairacres, NM 88033<br>PH: 505-936-5807 or 575-526-9084 | FAX: 877-702-8014 |
| **SOUTHEAST** | Care Network Resource Assistance Group (CNRAG), Inc.<br>PO Box 1680 Fairacres, NM 88033<br>PH: 505-936-5807 or 575-526-9084 | FAX: 877-702-8014 |
| **SOUTHWEST** | Care Network Resource Assistance Group (CNRAG), Inc.<br>PO Box 1680 Fairacres, NM 88033<br>PH: 505-936-5807 or 575-526-9084 | FAX: 877-702-8014 |

# Brain Injury Services Fund (BISF) Program

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

HEALTH CARE AUTHORITY

# TIP SHEET

**Revised January 2026**

**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 Health Care Authority.

**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 a 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. You can also get help filling out the application from the Brain Injury Resource Center listed below.

**For Information, Referrals and Resources:**

Call the NM Brain Injury Resource Center (NMBIRC) at BIANM:
1-844-3NM-BIRC (1-844-366-2472) or 505-292-7414

Visit the NMBIRC Website:
https://www.braininjurynm.org/nm-brain-injury-resource-center/

Visit the New Mexico Brain Injury Resource Center:

3150 Carlisle Blvd NE, Ste. 208
Albuquerque, NM 87110

## BISF SERVICE COORDINATION AGENCIES:

### METRO REGION

CNRAG, Inc.
PO Box 1680
Fairacres, NM 88033
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.
PO Box 1680
Fairacres, NM 88033
575-936-5807
575-526-9084

### SOUTHEAST REGION

CNRAG, Inc.
PO Box 1680
Fairacres, NM 88033
575-936-5807
575-526-9084

### SOUTHWEST REGION

CNRAG, Inc.
PO Box 1680
Fairacres, NM 88033
575-936-5807
575-526-9084

HUMAN SERVICES
DEPARTMENT
MEDICAL ASSISTANCE DIVISION

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

**NM Brain Injury Resource Center**
**Brain Injury Alliance of New Mexico**
**3150 Carlisle Blvd NE Ste 208**
**Albuquerque, NM 87110**
**Tel: 1-844-3NM-BIRC; 1-844-366-2472**
**Email:nmbirc@braininjurynm.org**
**Website: https://www.braininjurynm.com**

**BISF Program Coordinator: Crystal Cantu, CBIS**
**Exempt Services and Support Bureau (ESPB)**
**Medical Assistance Division (MAD)**
**Health Care Authority (HCA)**
**PO Box 2348**
**Santa Fe, NM 87507-2348**
**https://www.hsd.state.nm.us/LookingForAssistance/brain-injury.aspx**
**E-mail:BISF.HCA@hca.nm.gov**
**Phone: (505) 660-1335**

**For other helpful community resources, please visit:**
https://www.braininjurynm.org/nm-brain-injury-resource-center/
**or click here: NMBIRC**