



VDA WEEKLY E-MAILING

December 31, 2013

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ACL Weekly Update

Here is a link to the weekly Administration for Community Living (ACL) update:

<http://www.acl.gov/NewsRoom/eNewsletter/CurrentNewsLetter.pdf>

NASUAD Weekly Update

Here is a link to the weekly National Association of States United for Aging and Disabilities (NASUAD) update where you can sign up or view the current and archived editions:

http://www.nasuad.org/newsroom/friday_updates/friday_updates.html

Important Changes to Medicare Coverage in 2014

Kathy Miller, Director of Programs

As of **November 19, 2013**, the Centers for Medicare & Medicaid Services (CMS) requires additional and stricter criteria for meeting the definition of "homebound" status for home health care coverage. In upholding the recent Jimmo vs. Sebelius settlement, CMS revised its policy

Note: The web links in this document may change over time. DARS-VDA does not attempt to refresh the links once the week has passed. However, this document is maintained on the web for a period of time as a reference. Some links may require registration.

1610 Forest Avenue • Suite 100 • Henrico, VA 23229

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manual to clarify that a person cannot be denied skilled care coverage solely because his condition may not improve or has "plateaued."

[Homebound Definition](#)

[No Improvement Standard](#)

Visions for Aging in Place- Meeting and Webinar Announcement

Kathy Miller, Director of Programs

Visions for Aging in Place – Challenges for the Future”

Featuring Henry Cisneros, Chairman of CityView and former Secretary of HUD

The HUD Office of Policy Development & Research is sponsoring “Visions for Aging in Place – Challenges for the Future” that will be held on January 9, 2014. If you would like to attend, please visit the HUD [website](#) to register or view the webcast information.

Increasing life expectancy, a declining birth rate, and the aging of the baby boom generation will dramatically increase the number and proportion of the U.S. population over the age of 62 in the coming decades. Aging of the population presents challenges and questions including where people will live and how they will obtain the support and care they will require as they grow older.

Attend this special update to hear about these challenges and the economics of aging in place, social service demands, technology and physical requirements, community planning, and government programs. Come hear how housing can be a platform for improved lifestyles for the aging population and enable health care cost savings.

Following Secretary Cisneros’ remarks a panel will examine the issues.

- Jennifer Ho, Moderator, Senior Advisor on Housing and Services in the Office of the Secretary, HUD
- Judith Willett, National Director of the Village to Village Network
- Alisha Sanders, Senior Policy Researcher at the Leading Age Center for Applied Research
- James Toews, Senior Policy Analyst, Administration for Community Living, U.S. Department of Health and Human Services



When:

January 9, 2014, 2:00-4:00 PM

Where:

Brooke-Mondale Auditorium
HUD Headquarters

If you would like to attend, please visit the HUD [website](#) to register or view the webcast information.

VA Brain Injury Council Seeking Nominations

On behalf of Kristie Chamberlain, Brain Injury Services Coordination Unit

The Virginia Brain Injury Council, Nominations and Elections committee is seeking public nominations for review to assist in developing a slate for the Commissioner appointment of At-Large (voting) members.

This process requires the Council's Nominations and Elections committee to seek nominees to fill open positions. Nominated individuals will be reviewed and the committee will present the Council with a slate of two names/open position. The Council then submits the slate, once endorsed by the Council, to the Commissioner of DARS for final appointment. *A nomination does NOT guarantee you will be on the slate and making the slate does not guarantee Commissioner appointment.*

Proposed Nominee Forms are due back to the DARS Staff on Behalf of the Nominations & Elections Committee by: Monday, January 6, 2014 at 3 PM. Forms can be submitted via email, Kristie.chamberlain@dars.virginia.gov; fax: 804-662-7663 or mail: Kristie Chamberlain, VBIC Nominations, DARS, 8004 Franklin Farms Drive, Henrico VA 23229.

[Nominee Form](#)

There are a total of three (3) At-Large (Voting) Member Positions to be filled (the Commissioner makes the final appointment):

- **ONE SLOT: survivor** (a person who has sustained a brain injury), **family member/caregiver**, or **representative of a person with a brain injury** (any of these areas can be nominated)

and



- TWO SLOTS: individuals who are licensed, registered, or certified healthcare professionals as regulated by the Virginia Department of Health Professions

The Nominations and Elections Committee encourages **minority and rural representation** on the Council, as well as the recruitment of **veterans with combat-related injuries**. The DARS Commissioner has specifically directed the Council to be diverse, inclusive, and representative of the population of the Commonwealth. The Nominations and Elections committee will review all nominations submitted.

- At-Large Member Positions as described in Articles IV and VII of the by-laws (<http://www.vadrs.org/vbic.asp#Laws>) will serve a three-year term. At-Large Members may not serve two terms consecutively. Consistent with the elections process, terms of at-large members are effective April through March of the calendar year.
- At-Large Members are asked to attend four (4) regularly scheduled meetings per year in Richmond (or an otherwise noted location) and are required to attend at least two (2) regularly scheduled meetings per year. The meeting dates are on Fridays from 1-4 p.m. unless otherwise noted and are held the fourth Friday during the months of January, April, July and October (unless another time is stated). Any member (standing, at-large, or officer) who misses two consecutive meetings shall be notified by the Chair or designee that his/her membership status is at risk of termination. Any member who misses three (3) consecutive meetings shall be terminated at the third missed meeting. The Chair or designee shall notify the individual by phone or letter that his/her membership has been terminated.
- The Nominating Committee reviews Proposed Nominee Forms and will prepare a slate of at least two (2) names for each open position which, once voted upon by the Council, will be presented to the Commissioner of the Department for Aging & Rehabilitative Services (DARS) for final appointment in the weeks following the January 2014 meeting. The Commissioner of DARS makes final appointment.
- Timeline for Nominations and Elections of Members.

Solicitation of Nominees. The Nominations and Elections Committee will solicit nominees for Council membership and will prepare a slate of candidates to be presented to the membership at least ten (10) days prior to the January 24, 2013 meeting. The slate voted upon at the Council meeting will then be presented to the DARS Commissioner for final appointment within weeks of the meeting. The Commissioner makes the final appointment.



DIVISION FOR THE AGING
VIRGINIA DEPARTMENT FOR AGING
AND REHABILITATIVE SERVICES

Letters will be mailed in early February to anyone who has been nominated, informing them of the results of their nomination. Successful appointees will be notified via telephone/email and letter. **Membership becomes effective at the April 25, 2014 meeting.**

New Member Orientation. There is a new member orientation held just prior to the April 25, 2014 meeting (11-12:30 pm with lunch provided). New members will receive an overview of the Council's history, mission, and purpose as well as an overview of their role and responsibilities on the Council. If new members wish to have 1:1 with staff or a liaison from the Council, accommodations for that can be made.

If you have questions on this process, please contact me!

Thanks,

Kristie Chamberlain

Brain Injury Services Coordination Unit

Community Based Services Division

Virginia Department for Aging and Rehabilitative Services

8004 Franklin Farms Drive, Henrico, Virginia 23229

Phone: 804.662.7154/ 1800.552.5019

Fax: 804.662.7663

[Email: kristie.chamberlain@dars.virginia.gov](mailto:kristie.chamberlain@dars.virginia.gov)

[Web: www.vadrs.org](http://www.vadrs.org)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



RELEASED products from the Medicare Learning Network® (MLN)
["Transitional Care Management Services,"](#) Fact Sheet, ICN 908628, Hard Copy only.

MLN Matters® Number: MM8444

Related Change Request (CR) #: CR 8444

Related CR Release Date: October 18, 2013

Effective Date: November 19, 2013

Related CR Transmittal #: R172BP

Implementation Date: November 19, 2013

Home Health - Clarification to Benefit Policy Manual Language on "Confined to the Home" Definition

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8444 which requires Medicare contractors to be aware of the clarification of the definition of "confined to the home" as stated in the revised section 30.1.1 of Chapter 7 of the "Medicare Benefit Policy Manual". CR8444 clarifies the definition of the patient being "confined to the home" to more accurately reflect the definition as articulated at Section 1835(a) of the Social Security Act (the Act). In addition, the Centers for Medicare & Medicaid Services (CMS) removed vague terms, such as "generally speaking", to ensure the definition is clear and specific.

These changes present the requirements first and more closely align the CMS policy manual with the Act. This will prevent confusion, promote a clearer enforcement of the statute, and provide more definitive guidance to HHAs in order to foster compliance.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.

Background

In the Calendar Year (CY) 2012 Home Health (HH) Prospective Payment System (PPS) proposed rule published on July 12, 2011, CMS proposed their intent to provide clarification to the Benefit Policy Manual language regarding the definition of "confined to the home". In the CY 2012 HH PPS final rule published on November 4, 2011 (FR 76 68599-68600), CMS finalized that proposal. In order to clarify the definition, CMS is amending its policy manual as follows:

For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria-One:

The patient must either:

Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

OR

Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.

Criteria-Two:

There must exist a normal inability to leave home;

AND

Leaving home must require a considerable and taxing effort.

Additional Information

The official instruction, CR 8444 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R172BP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



MLN Matters® Number: MM8458 Revised

Related Change Request (CR) #: CR 8458

Related CR Release Date: December 13, 2013

Effective Date: January 7, 2014

Related CR Transmittal #: R176BP

Implementation Date: January 7, 2014

Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo vs. Sebellius*

Note: This article was revised on December 16, 2013, to reflect the revised CR8458 issued on December 13. In the article, the CR release date, transmittal number, and the Web address are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs); Inpatient Rehabilitation Facilities (IRFs); Home Health Agencies (HHAs); providers and suppliers of therapy services under the Outpatient Therapy (OPT) Benefit – including Critical Access Hospitals (CAHs), hospitals, rehabilitation agencies, SNFs, HHAs, physicians, certain non-physician practitioners, and therapists in private practice – submitting claims to Medicare contractors (Parts A/B Medicare Administrative Contractors (MACs) and Medicare Advantage Organizations) for services to Medicare beneficiaries, including physical therapy, occupational therapy, and speech-language pathology services.

What You Need to Know

This article is based on Change Request (CR) 8458, which updates portions of the "Medicare Benefit Policy Manual" (MBPM) to clarify key components of SNF, IRF, HH, and OPT coverage requirements pursuant to the settlement agreement in the case of *Jimmo v. Sebellius*. Nothing in this settlement agreement modifies, contracts, or expands the existing eligibility requirements for Medicare coverage.

Background

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In accordance with the *Jimmo v. Sebelius* Settlement Agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant program manuals used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "...does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The following are some significant aspects of the manual clarifications now being issued:

- **No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required.** Medicare has long recognized that even in situations where no improvement is expected, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). For example, the longstanding SNF level of care regulations, specify that the ". . . restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need . . . skilled services . . ." [42 CFR 409.32(c)] (This regulation is available at <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec409-32.pdf> on the Internet.)

While the example included in this provision pertains specifically to skilled nursing services, we also wish to clarify that, the concept of skilled therapy services can similarly involve not only services that are restorative in nature (or "rehabilitative" therapy in the OPT setting) but, if certain standards are met, maintenance therapy as well:

- Restorative/Rehabilitative therapy. In evaluating a claim for skilled therapy that is restorative/rehabilitative (i.e., whose goal and/or purpose is to reverse, in whole or in part, a previous loss of function), it would be entirely appropriate to consider the beneficiary's potential for improvement from the services. We note that such a consideration must always be made in the IRF setting, where skilled therapy must be reasonably expected to improve the patient's functional capacity or adaptation to impairments in order to be covered.
- Maintenance therapy. Even if no improvement is expected, under the SNF, HH, and OPT coverage standards, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration. Skilled maintenance therapy may be covered when the particular patient's special medical complications or the complexity of the therapy procedures require skilled care.

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Accordingly, these revisions to the MBPM clarify that a beneficiary's lack of restoration potential cannot serve as the basis for denying coverage in this context. Rather, such coverage depends upon an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Moreover, when the individualized assessment demonstrates that skilled care is, in fact, needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, such care is covered (assuming all other applicable requirements are met). Conversely, coverage in this context would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of *nonskilled* personnel.

Medicare has never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly. Therefore, denial notices should contain an accurate summary of the reason for denial, which should be based on the beneficiary's need for skilled care and not be based on lack of improvement for a beneficiary who requires skilled maintenance nursing services or therapy services as part of a maintenance program in the SNF, HH, or OPT settings.

In the MBPM (the Manual within which all revisions were made by CR8458), the revised Chapter 15, Section 220 specifically discusses Part B coverage under the OPT benefit. In that chapter, both rehabilitative and maintenance therapy are addressed. Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. A "MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness." No mention of improving the patient's condition is noted within the MP definition.

- **Enhanced guidance on appropriate documentation.** Portions of the revised manual provisions now include additional material on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case. Thus, even though the terms of the *Jimmo* settlement do not include an explicit reference to documentation requirements as such, CMS has nevertheless decided to use this opportunity to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios. An example of this material appears in a new Section 30.2.2.1 of the MBPM's revised Chapter 8, in the guidelines for SNF coverage under Part A.

We note that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although it does identify certain vague phrases like "patient tolerated treatment well," "continue with POC," and "patient remains

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stable" as being *insufficiently explanatory* to establish coverage). Rather, as indicated previously, coverage determinations must consider the *entirety* of the clinical evidence in the file, and our enhanced guidance on documentation is intended simply to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received—which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Further, as noted in the discussion of OPT coverage under Part B in Section 220.3.D of the MBPM, Chapter 15, care must be taken to assure that documentation justifies the necessity of the skilled services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and, there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- In the case of maintenance therapy, the skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services cannot be safely and effectively carried out by the beneficiary personally or with the assistance of non-therapists, including unskilled caregivers.

The Settlement Agreement. The *Jimmo v. Sebelius* settlement agreement itself includes language specifying that **"Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."** Rather, the intent is to clarify Medicare's longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. As such, the revised manual material now being issued does not represent an expansion of coverage, but rather, provides clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the existing policy.

Additional Information

The official instruction, CR 8458, issued to your Medicare contractor regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R176BP.pdf> on the CMS website. All of the revised portions of the "Medicare Benefit Policy Manual" are a part of CR8458.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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Virginia Brain Injury Council

Nominating Policy & Procedures
for Election of At-Large Members

**Proposed Nominee Forms are due back to the
DARS Staff on Behalf of the Nominations & Elections Committee by:
Friday, Monday, January 6, 2014 at 3 PM**

There are a total of three (3) At-Large (Voting) Member Positions to be filled:

- ONE SLOT: *survivor* (a person who has sustained a brain injury), *family member/caregiver*, or *representative of a person with a brain injury* (any of these areas can be nominated)
and
- TWO SLOTS: individuals who are licensed, registered, or certified healthcare professionals as regulated by the Virginia Department of Health Professions

The Nominations and Elections Committee encourages **minority and rural representation** on the Council, as well as the recruitment of **veterans with combat-related injuries**. The DARS Commissioner has specifically directed the Council to be diverse, inclusive, and representative of the population of the Commonwealth.

- At-Large Member Positions as described in Articles IV and VII of the by-laws will serve a three-year term. At-Large Members may not serve two terms consecutively. Consistent with the elections process, terms of at-large members are effective April through March of the calendar year.
- At-Large Members are asked to attend four (4) regularly scheduled meetings per year in Richmond (or an otherwise noted location) and are required to attend at least two (2) regularly scheduled meetings per year. The meeting dates are on Fridays from 1-4 p.m. unless otherwise noted and are held the fourth Friday during the months of January, April, July and October (unless another time is stated). Any member (standing, at-large, or officer) who misses two consecutive meetings shall be notified by the Chair or designee that his/her membership status is at risk of termination. Any member who misses three (3) consecutive meetings shall be terminated at the third missed meeting. The Chair or designee shall notify the individual by phone or letter that his/her membership has been terminated.

Note: *If you have additional comments or information such as a resume or curriculum vitae that would be useful in the consideration the proposed nominee, please attach to this form. Thank you*

- The Nominating Committee reviews Proposed Nominee Forms and contacts the candidates to confirm their interest in serving on the Council (**this contact/and or meeting does not guarantee appointment to the Council**). The Committee will prepare a slate of at least two (2) names for each open position which, once voted upon by the Council, will be presented to the Commissioner of the Department for Aging & Rehabilitative Services (DARS) for final appointment in the weeks following the January 2014 meeting. The Commissioner of DARS makes final appointment.
- Timeline for Nominations and Elections of Members.

Solicitation of Nominees. The Nominations and Elections Committee will solicit nominees for Council membership and will prepare a slate of candidates to be presented to the membership at least ten (10) days prior to the January 24, 2013 meeting. The slate voted upon at the Council meeting will then be presented to the DARS Commissioner for final appointment within weeks of the meeting. The Commissioner makes the final appointment.

Letters will be mailed following the January 2014 meeting to anyone who has been nominated, informing them of the results of their nomination. Successful appointees will be notified via telephone and letter. Membership becomes effective at the April 25, 2014 meeting.

New Member Orientation. **There is a new member orientation held just prior to the April 25, 2014 meeting (11-12:30 pm with lunch provided). New members will receive an overview of the Council's history, mission, and purpose as well as an overview of their role and responsibilities on the Council.** If new members wish to have 1:1 with staff or a liaison from the Council, accommodations for that can be made.

Note: *If you have additional comments or information such as a resume or curriculum vitae that would be useful in the consideration the proposed nominee, please attach to this form. Thank you*

**PROPOSED NOMINEE FOR AT-LARGE VOTING MEMBERSHIP POSITIONS
ON THE VIRGINIA BRAIN INJURY COUNCIL**

CONFIDENTIAL WORKING PAPERS

Return form to DARS Staff by Wednesday, December 18, 2013

ATTN: Nominations & Elections Committee,
Virginia Brain Injury Council, c/o Kristie Chamberlain, DARS
8004 Franklin Farms Drive, Henrico, VA 23229
Fax: (804) 662-7663; E-mail: kristie.chamberlain@dars.virginia.gov

[PLEASE PRINT OR TYPE]

This nomination is for an at-large (voting) member of the Council.

Name of Proposed Nominee: _____

Home Address: _____

City/State: _____ Zip: _____

Phone: _____ Cell Phone: _____

Personal E-mail: _____

Profession: _____

Title: _____

Work Address: _____

City/State: _____ Zip: _____ Telephone: _____

Work Email: _____

Please complete page 2 of the nomination form to complete this application.

Note: If you have additional comments or information such as a resume or curriculum vitae that would be useful in the consideration the proposed nominee, please attach to this form. Thank you

The Proposed Nominee is (check one):

- Survivor (an individual who sustained a brain injury)
- Family member
- Caregiver
- Representative of an individual with a brain injury
- Individual licensed, registered, or certified as a healthcare professional
(Examples: MD, PhD/PsyD, LPC/LCSW, RN, PT/OT/SLP, etc.)

OPTIONAL (please mark all that may apply)

- ___ Age 18-24 ___ Age 25-34 ___ Age 35-44 ___ Age 45-54 ___ Age 55-64 ___ Age 65+
- Gender: ___ Male ___ Female
- Race: ___ Black or African American ___ American Indian ___ Asian ___ Native Hawaiian or Other Pacific Islander ___ White ___ Other: _____
- Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino
- ___ Veteran
- ___ Veteran (OIF: Operation Iraqi Freedom) ___ Veteran (OEF: Operation Enduring Freedom)
- Education: ___ HS Diploma ___ Some College ___ College Degree ___ Post Secondary Degree/Training

Background/areas of interest/expertise that would benefit VBIC: _____

I could contribute to VBIC in the following areas:

- | | |
|--|---|
| <input type="checkbox"/> Education | <input type="checkbox"/> Medical |
| <input type="checkbox"/> Government/
Advocacy | <input type="checkbox"/> Public Relations |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Veterans Issues |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Aging |

Current level of commitment to other organizations, boards, councils: _____

Why do you think you / individual you are nominating would be an asset to the Virginia Brain Injury Council? _____

Note: *If you have additional comments or information such as a resume or curriculum vitae that would be useful in the consideration the proposed nominee, please attach to this form. Thank you*