

ACL Traumatic Brain Injury State Partnership Grants Performance Measurement Reporting Tool

Updated June 9, 2020 for Grantee Completion

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A. Grant Activities (all grantees respond)

1. Which activities did you carry out as part of your ACL project using program funding during this reporting period? (Check all that apply)

- a. Partnership Development** - identifying and reaching out to new partners, coordinating and aligning activities, information exchange, collaboration on grant activities, collaboration on activities related to the grant
- b. Planning and Infrastructure Development** - state planning, policy and procedures development, state councils, needs assessment, surveillance, registry, IT systems
- c. Information and Referral/Assistance (I&R/A)** - bringing people and services together, answering questions from individuals and families about human service resources, helping people get connected to public benefits, sharing information about available services like home care and adaptive equipment. Note: I&R is about bringing people and services together. Individuals may reach out once or many times, but I&R typically does not involve ongoing engagement of individuals like Resource Facilitation. If the description provided here does not align with how your program defines this activity, please provide your definition here:

Click or tap here to enter text.

- d. Screening** - using a standardized procedure, structured interview, or tool to elicit the lifetime history of TBI for an individual. Screening can be used for clinical, research, programmatic, eligibility determination, service delivery or treatment purposes. If the description provided here does not align with how your program defines this activity, please provide your definition here:

Click or tap here to enter text.

- e. Resource Facilitation** – this category of activity could include development of resources such as databases, resource directories, and communications tools to improve service delivery. It could also mean providing assistance through an accessible, holistic, and person-centered process that engages individuals in decision making about their options, preferences, values, and financial resources and helps connect them with programming, services and supports they choose. In some states this may be called service coordination, service navigation, case management, options counseling, or person centered counseling. Resource facilitation could be of short term or long term duration. If the description provided here does not align with how your program defines this activity, please provide your definition here:

Click or tap here to enter text.

- f. Training, Outreach and Awareness** - continuing education for professionals who may work with or provide services for people who have experienced a TBI, training for individuals who have experienced a TBI, public education and awareness, training for caregivers, on-the-job training for agency staff, cross-training with partnering agencies. If the description provided here does not align with how your program defines this activity, please provide your definition here:

Click or tap here to enter text.

- Other 1 (Describe):** Click or tap here to enter text.

- Other 2 (Describe):** Click or tap here to enter text.

- Other 3 (Describe):** Click or tap here to enter text.

2. Did you target or limit some or all of your grant activities to support people in a particular setting or particular population during this reporting period? If yes, please select all that apply.

[NOTE: IF ALL OF THE ACTIVITIES ARE DESIGNED TO MORE GENERALLY SUPPORT ALL TBI SURVIVORS IN YOUR STATE, **DO NOT CHECK 'YES, ALL' OR 'YES, SOME' FOR ANY SETTING/POPULATION. ONLY CHECK 'NO' BELOW AND DO NOT FILL OUT THE REST OF THE TABLE.**]

- NO, all of our activities are designed to more generally support all TBI survivors in our state**

Setting/Population	YES, ALL of our activities were primarily targeted to this group	YES, SOME of our activities were primarily targeted to this group
a. Athletes	<input type="checkbox"/>	<input type="checkbox"/>
b. Children and youth (younger than 22)	<input type="checkbox"/>	<input type="checkbox"/>
c. Adults (22-59)	<input type="checkbox"/>	<input type="checkbox"/>
d. Older adults (60 or over)	<input type="checkbox"/>	<input type="checkbox"/>
e. People who are homeless	<input type="checkbox"/>	<input type="checkbox"/>
f. People who are hospitalized	<input type="checkbox"/>	<input type="checkbox"/>
g. People who are incarcerated or formerly incarcerated	<input type="checkbox"/>	<input type="checkbox"/>
h. Medicaid home and community-based services participants	<input type="checkbox"/>	<input type="checkbox"/>
i. Native Americans	<input type="checkbox"/>	<input type="checkbox"/>
j. Other ethnic, racial or linguistic minorities	<input type="checkbox"/>	<input type="checkbox"/>
k. Residents of nursing facilities, rehab facilities or ICFs/MR	<input type="checkbox"/>	<input type="checkbox"/>

Setting/Population	YES, ALL of our activities were primarily targeted to this group	YES, SOME of our activities were primarily targeted to this group
l. Rural populations	<input type="checkbox"/>	<input type="checkbox"/>
m. People who experience unhealthy substance use or a substance use disorder	<input type="checkbox"/>	<input type="checkbox"/>
n. Students	<input type="checkbox"/>	<input type="checkbox"/>
o. Veterans or current service members	<input type="checkbox"/>	<input type="checkbox"/>
p. People who are victims of crime, domestic violence, or intimate partner violence	<input type="checkbox"/>	<input type="checkbox"/>
q. Other 1 (describe)	<input type="checkbox"/>	<input type="checkbox"/>
r. Other 2 (describe)	<input type="checkbox"/>	<input type="checkbox"/>
s. Other 3 (describe)	<input type="checkbox"/>	<input type="checkbox"/>

3. Percent of your state’s counties (parishes or boroughs) targeted and reached through your grant’s activities during this reporting period:

- a. Total number of counties in state #Click or tap here to enter text.
- b. Counties targeted for this project #Click or tap here to enter text.
- c. Counties reached this reporting period #Click or tap here to enter text.

4. For each of your grant activities, please provide how much of your total program funding you spent in the last completed grant year in support of each of the different activities listed below, rounded to closest \$1,000. [NOTE: THIS QUESTION WILL BE ASKED ONCE A YEAR ABOUT THE LAST COMPLETED GRANT YEAR. THE AMOUNT IN ROW ‘j’ SHOULD TOTAL THE AMOUNTS IN ROWS ‘a’ THROUGH ‘i’].

- a. Partnership Development \$Click or tap here to enter text.
- b. Planning and Infrastructure Development \$Click or tap here to enter text.
- c. Information and Referral/Assistance \$Click or tap here to enter text.
- d. Screening \$Click or tap here to enter text.
- e. Resource Facilitation \$Click or tap here to enter text.
- f. Training, Outreach and Awareness \$Click or tap here to enter text.
- g. Other 1 (Describe): \$Click or tap here to enter text.
- h. Other 2 (Describe): \$Click or tap here to enter text.
- i. Funds not yet spent including any carryover funds from last fiscal year \$Click or tap here to enter text.
- j. **Total Program Funding** \$Click or tap here to enter text.

5. Did your project use any evidence-based practices, interventions, or programs as part of your grant activities during this reporting period?

YES NO

If yes, please describe:

Click or tap here to enter text.

B. Partnership Activities (all grantees respond)

6. Which organizations in your state received funding through the ACL State Partnership Program to carry out and/or support grant activities (primary awardee and sub-awarded partners) in this reporting period?

a. Lead Grantee Agency

i. **Name of organization:** Click or tap here to enter text.

ii. **Type of organization (select all the designations below that apply to this organization):**

- State Medicaid Agency
- State Vocational Rehabilitation Agency,
- State Department of Education
- State Department of Criminal Justice/Corrections
- State Unit on Aging
- State Department for Developmental Disabilities
- State Behavioral and/or Mental Health Agency
- State Department of Public Health
- Tribal Council
- Other State Agency
- University Center on Excellence for Developmental Disabilities
- University
- Other (Specify): Click or tap here to enter text.

b. Funded Partner 1 (If applicable complete; if not go to Question 7)

i. **Name of organization:** Click or tap here to enter text.

ii. **Type of organization (select all the designations below that apply to this organization):**

- State Medicaid Agency
- State Vocational Rehabilitation Agency,
- State Department of Education
- State Department of Criminal Justice/Corrections
- State Unit on Aging
- State Department for Developmental Disabilities
- State Behavioral and/or Mental Health Agency
- State Department of Public Health
- Tribal Council/Organization
- Other State Agency
- University Center on Excellence for Developmental Disabilities.
- University
- State Independent Living Council
- State I/DD Council
- Affiliate of National Brain Injury Organization
- County or Local Government Entity,
- Community-Based Services Organization (e.g. CAA, ADRC, AAA, CIL),
- Public Health Department or Clinic
- Recovery or Substance Abuse Treatment Center
- VA Medical Center
- Other Health Care Provider
- University
- Private Business/Employer
- Other (Specify): Click or tap here to enter text.

iii. **Is this partner new this reporting period?** Yes No

Funded Partner 2 (If applicable complete; if not go to Question 7)

i. **Name of organization:** Click or tap here to enter text.

ii. **Type of organization (select all the designations below that apply to this organization):**

- State Medicaid Agency
- State Vocational Rehabilitation Agency,
- State Department of Education
- State Department of Criminal Justice/Corrections
- State Unit on Aging
- State Department for Developmental Disabilities
- State Behavioral and/or Mental Health Agency
- State Department of Public Health
- Tribal Council/Organization
- Other State Agency
- University Center on Excellence for Developmental Disabilities.
- University
- State Independent Living Council
- State I/DD Council
- Affiliate of National Brain Injury Organization
- County or Local Government Entity,
- Community-Based Services Organization (e.g. CAA, ADRC, AAA, CIL),
- Public Health Department or Clinic
- Recovery or Substance Abuse Treatment Center
- VA Medical Center
- Other Health Care Provider
- University
- Private Business/Employer
- Other (Specify): Click or tap here to enter text.

iii. **Is this partner new this reporting period?** Yes No

Funded Partner 3 (If applicable complete, if not go to Question 7)

i. **Name of organization:** Click or tap here to enter text.

ii. **Type of organization (select all the designations below that apply to this organization):**

- State Medicaid Agency
- State Vocational Rehabilitation Agency,
- State Department of Education
- State Department of Criminal Justice/Corrections
- State Unit on Aging
- State Department for Developmental Disabilities
- State Behavioral and/or Mental Health Agency
- State Department of Public Health
- Tribal Council/Organization
- Other State Agency
- University Center on Excellence for Developmental Disabilities.
- University
- State Independent Living Council
- State I/DD Council
- Affiliate of National Brain Injury Organization
- County or Local Government Entity,
- Community-Based Services Organization (e.g. CAA, ADRC, AAA, CIL),
- Public Health Department or Clinic
- Recovery or Substance Abuse Treatment Center
- VA Medical Center
- Other Health Care Provider
- University
- Private Business/Employer
- Other (Specify):Click or tap here to enter text.

iii. **Is this partner new this reporting period?** Yes No

LIST ADDITIONAL FUNDED PARTNERS, AND ORGANIZATION TYPE, AS NEEDED IN THE FIELD BELOW:

7. Which types of organizations are program partners and support program activities but *did not* receive program funds during this reporting period?

a. Types of Unfunded Partners

Select all the types of organizations that are unfunded partners and indicate if this type of organization is new (as of this reporting period) or a continuing partner.

- State Medicaid Agency
- State Vocational Rehabilitation Agency,
- State Department of Education
- State Department of Criminal Justice/Corrections
- State Unit on Aging
- State Department for Developmental Disabilities
- State Behavioral and/or Mental Health Agency
- State Department of Public Health
- Protection and Advocacy Programs
- Tribal Council/Organization
- Other State Agency
- University Center on Excellence for Developmental Disabilities.
- University
- State Independent Living Council
- State I/DD Council
- Affiliate of National Brain Injury Organization
- County or Local Government Entity
- Community-Based Services Organization (e.g. CAA, ADRC, AAA, CIL),
- Public Health Department or Clinic
- Recovery or Substance Abuse Treatment Center
- VA Medical Center
- Other Health Care Provider
- University
- Private Business/Employer
- Other (Specify): Click or tap here to enter text.

8. Is there anything else you would like to let ACL know about your Partnership activities during this reporting period? *This question is not mandatory.*

Click or tap here to enter text.

C. Planning and Infrastructure Development (all grantees respond)

9. Please list your advisory council members for this project period and place a check by their affiliations. You may check all that apply if a person represents two or more affiliated entities.

GRANTEES CAN ADD THE NAMES BELOW OR UPLOAD AN ATTACHMENT WITH THE ROSTER OF NAMES. GRANTEES CAN ADD AS MANY ADVISORY COUNCIL MEMBERS AS THEY NEED.

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council representative	Aging and Disability Resource Center representative	Protection & Advocacy agency representative	Long-term care ombudsman representative	TBI Model Systems representative	Representative from an Affiliate of National Brain Injury Organization	Other (describe)
Example: John Smith	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council representative	Aging and Disability Resource Center representative	Protection & Advocacy agency representative	Long-term care ombudsman representative	TBI Model Systems representative	Representative from an Affiliate of National Brain Injury Organization	Other (describe)
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
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Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council representative	Aging and Disability Resource Center representative	Protection & Advocacy agency representative	Long-term care ombudsman representative	TBI Model Systems representative	Representative from an Affiliate of National Brain Injury Organization	Other (describe)
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
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Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
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Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council representative	Aging and Disability Resource Center representative	Protection & Advocacy agency representative	Long-term care ombudsman representative	TBI Model Systems representative	Representative from an Affiliate of National Brain Injury Organization	Other (describe)
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
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Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council representative	Aging and Disability Resource Center representative	Protection & Advocacy agency representative	Long-term care ombudsman representative	TBI Model Systems representative	Representative from an Affiliate of National Brain Injury Organization	Other (describe)
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
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Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council representative	Aging and Disability Resource Center representative	Protection & Advocacy agency representative	Long-term care ombudsman representative	TBI Model Systems representative	Representative from an Affiliate of National Brain Injury Organization	Other (describe)
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
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Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.
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Click or tap here to enter text.	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Click or tap here to enter text.

10. Estimate the number of people in your state who have experienced a TBI and are getting some kind of Medicaid Home and Community Based Services or supports.

a. Estimate how many people living in your state have experienced a TBI: Click or tap here to enter text.

i. Of the total in 'a' above, estimate how many people who have experienced a TBI are currently receiving HCBS through a Medicaid TBI waiver: Click or tap here to enter text.

ii. Of the total in 'a' above, estimate how many people who have experienced a TBI are in your grant's target population (e.g. based on where they live in the state, their age, setting in which they live or some other demographic or criteria): Click or tap here to enter text.

(a) Of the total in 'a' above, estimate how many people in your target population are currently receiving services or supports that help them live in a home or community setting through a Medicaid waiver or some other kind of publicly funded program (e.g. state HCBS program, Rehabilitation Services Act, Older Americans Act): Click or tap here to enter text.

b. Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

Click or tap here to enter text.

11. What planning and infrastructure accomplishments or activities of the last six months do you think have been or will be most impactful? Consider how you are working toward systems change and what progress you are seeing.

Click or tap here to enter text.

12. Is there anything else you would like to let ACL know about your planning and infrastructure activities during this reporting period? These activities may include needs assessments, state plans, and registries *This question is not mandatory.*

Click or tap here to enter text.

D. Information and Referral/Assistance (if applicable to grant activities)

13. How many I&R/A contacts were made in this reporting period (across all funded partners providing grant-related I&R/A)?

a. How many people live in the collective service areas of the organization or organizations providing I&R/A with grant funding?:[Click or tap here to enter text.](#)

Total number of contacts made to organizations that use program funds to support some or all of their I&R/A activities: [#Click or tap here to enter text.](#)

Total number of contacts made to these funded partners regarding TBI in reporting period: [#Click or tap here to enter text.](#)

b. Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

[Click or tap here to enter text.](#)

14. How often are different types of services referred for I&R/A callers who have experienced a TBI, their family members, or other professionals and service providers during this reporting period across all funded partners providing grant-related I&R/A? Please select an option for each type of referral.

Type of Referral	COMMONLY	OCCASIONALLY	NEVER	UNKNOWN
a. Grant-funded resource facilitation, service coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Other type of resource facilitation, service coordination (provided by other unfunded partners or other organizations such as an affiliate of national brain injury organization, ADRC, CIL, other ABI association, or other organization)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Older Americans Act services (e.g., nutrition services, LTC Ombudsman)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Behavioral health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Brain injury support groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Caregiver supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Independent living services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Domestic violence help services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Employment counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Type of Referral	COMMONLY	OCCASIONALLY	NEVER	UNKNOWN
j. Educational counseling or school disability services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Health insurance information or counseling (e.g. SHIP, Medicaid eligibility)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. General medical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Specialized TBI/ABI services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Homeless services provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Housing supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Medicaid waiver services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Physical, occupational, recreational or speech therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Legal or advocacy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Transportation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Veteran's hospital or clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Vocational rehabilitation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w. In-home services and supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. Other 1 (Specify) Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y. Other 2 (Specify) Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z. Other 3 (Specify) Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Is there anything else you would like to let ACL know about your I&R/A activities during this reporting period? *This question is not mandatory.*

Click or tap here to enter text.

E. Screening (if applicable to grant activities)

16. How many unduplicated people did you and your funded partners screen to identify a history of TBI during this reporting period (across all funded partners providing grant-related screening)? Please enter a number, or select zero or unknown, for each row.

SCREENING	NUMBER	ZERO	UNKNOWN
a. Total number of unduplicated people screened this reporting period	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
b. Number of people screened who were identified as having a history of TBI	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of people under age 22	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of people between 22-59	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of people 60 or older	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of veterans of any age	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>

17. Select which standardized instruments you or your partners used for screening procedures during this reporting period. (Select all that apply)

Instrument	Yes	No
a. The Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. A modified version of the OSU TBI-ID	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. The Brain Injury Screening Questionnaire (BISQ)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Defense and Veterans Brain Injury Center TBI Screening Tool (DVBIC TBI), also called The Brief Traumatic Brain Injury Screen (BTBIS)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. The Traumatic Brain Injury Screening Instrument (TBISI)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. HELPS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. Military Acute Concussion Evaluation (MACE)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Automated Neuropsychological Assessment Metrics (ANAM)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
i. Other 1 (Specify): Click or tap here to enter text.		
j. Other 2 (Specify): Click or tap here to enter text.		
k. Other 3 (Specify): Click or tap here to enter text.		

18. Of the people who have experienced a TBI whom you screened in this reporting period, how many were living in these following settings at the time of their screening? Please enter a positive number, or select zero or unknown, for each row.

LIVING SETTING	NUMBER	ZERO	UNKNOWN
a. On their own/independent	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
b. Homeless	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
c. With parent or grandparent	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
d. With immediate family	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
e. With friends or other extended family	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
f. Group home	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
g. Prison or Jail/Justice involved setting	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
h. Transitional living program or temporary housing	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
i. Community Based Neurobehavioral Rehabilitation Services	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
j. Nursing facility or in-patient rehab setting	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
k. Supervised living program	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
l. Assisted-living settings	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
m. Other 1 (Specify): Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
n. Other 2 (Specify): Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
o. Other 3 (Specify): Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):
Click or tap here to enter text.

19. Of the people who have experienced a TBI whom you screened during this reporting period, how many were in competitive, integrated employment and/or in school at the time of the screening? Please enter a number, or select zero or unknown, for each row.

	NUMBER	ZERO	UNKNOWN
a. Competitive, integrated employment	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
b. In school or training	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):
Click or tap here to enter text.

20. Is there anything else you would like to let ACL know about your screening activities this reporting period? *This question is not mandatory.*

Click or tap here to enter text.

F. Resource Facilitation (if applicable to grant activities)

21. For how many unduplicated people who have a TBI did you or your partners provide resource facilitation in this reporting period (across all funded partners providing grant-related resource facilitation)? Please enter a number, or select zero or unknown, for each row.

RESOURCE FACILITATION	NUMBER	ZERO	UNKNOWN
Total number of unduplicated people who have experienced a TBI who were provided with resource facilitation in this reporting period	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of people under age 22	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of people between 22-59	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of people 60 or older	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of veterans of any age	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):
Click or tap here to enter text.

22. What types of referrals did those providing Resource Facilitation make for people who have experienced a TBI and who received resource facilitation during this reporting period? Please select a response for each type of referral.

Type of Referral	COMMONLY	OCCASIONALLY	NEVER	UNKNOWN
a. Grant-funded resource facilitation, service coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Other type of resource facilitation, service coordination (provided by other unfunded partners or other organizations such as an affiliate of national brain injury organization, ADRC, CIL, other ABI association, or other organization)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Older Americans Act services (e.g., nutrition services, LTC Ombudsman)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Behavioral health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Brain injury support groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Caregiver supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Independent living services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Domestic violence help services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Type of Referral	COMMONLY	OCCASIONALLY	NEVER	UNKNOWN
i. Employment counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Educational counseling or school disability services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Health insurance information or counseling (e.g. SHIP, Medicaid eligibility)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. General medical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Specialized TBI/ABI services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Homeless services provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Housing supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Medicaid waiver services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Physical, occupational, recreational or speech therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Legal or advocacy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Transportation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Veteran's hospital or clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Vocational rehabilitation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w. In-home services and supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. Other 1 (Specify): Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y. Other 2 (Specify): Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z. Other 3 (Specify): Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. Of the people who have experienced a TBI for whom you provided resource facilitation this reporting period, how many were living in these different settings at the time you worked with them? Please enter a number, or select zero or unknown, for each row.

LIVING SETTING	NUMBER	ZERO	UNKNOWN
a. On their own/independent	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
b. Homeless	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
c. With parent or grandparent	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
d. With immediate family	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
e. With friends or other extended family	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
f. Group home	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
g. Prison or Jail/Justice involved setting	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
h. Transitional living program or temporary housing	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
i. Community Based Neurobehavioral Rehabilitation Services	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>

LIVING SETTING	NUMBER	ZERO	UNKNOWN
j. Nursing facility or in-patient rehab setting	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
k. Supervised living program	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
l. Assisted-living settings	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
m. Other (Specify): Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):
Click or tap here to enter text.

24. Of the people who have experienced a TBI for whom you provided resource facilitation this reporting period, how many were in competitive, integrated employment and/or in school while receiving resource facilitation? Please enter a number or select zero or unknown, for each row.

	NUMBER	ZERO	UNKNOWN
a. Competitive, integrated employment	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
b. In school or training	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):
Click or tap here to enter text.

25. Of the people who have experienced a TBI for whom you provided resource facilitation this reporting period, how many did you support through a transition from an institutional setting (e.g. criminal justice system, nursing facility) into the community? Please enter a number—or select zero, unknown, or not applicable—for each row.

	NUMBER	ZERO	UNKNOWN	N/A
a. Number transitioning from criminal justice system to community (with or without HCBS)	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Number transitioning from nursing facility/medical facility to community (with or without HCBS)	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Number transitioning from another setting to community (with or without HCBS) Describe: Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):
Click or tap here to enter text.

26. Is there anything else you would like to let ACL know about your resource facilitation efforts during this period? *This question is not mandatory.*

Click or tap here to enter text.

G. Training, Outreach and Awareness (if applicable to grant activities)

27. How many different types of people received grant-supported training in this reporting period (across all funded partners that provide training with program funds)? Please enter a number—or select zero, unknown, or not applicable—for each row.

	NUMBER	ZERO	UNKNOWN	N/A
a. Staff providing grant-related services	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff providing, I&R/A	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff conducting Screenings	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff providing Resource Facilitation	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Clinical/medical providers	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physicians	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency medical services providers/first responders	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other clinical/medical providers	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Coaches or other athletics personnel	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Domestic violence services staff	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Family, friends, informal caregivers	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Homeless services organization staff	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Individuals who have experienced a TBI	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. In-home services and supports staff	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Law enforcement personnel	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Prison or criminal justice system staff	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Protection and advocacy staff	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Residential rehabilitation center staff	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nursing home staff	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	NUMBER	ZERO	UNKNOWN	N/A
n. Universities, colleges, or school staff (excluding school coaches)	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Veterans & military organization staff	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Other 1 (Describe): Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Other 2 (Describe): Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Other 3 (Describe): Click or tap here to enter text.	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):
Click or tap here to enter text.

28. Please provide the number of grant-sponsored trainings that took place this reporting period, by topic area and include the number of attendees. Please enter either a positive number, zero (0), unknown, or not applicable in every field.

Note: “grant-sponsored trainings” refers to those using program funds or state matching funds.

Topic Area	Number of Trainings	Number of Attendees
a. TBI Basics	Click or tap here to enter text.	Click or tap here to enter text.
b. Aging and TBI	Click or tap here to enter text.	Click or tap here to enter text.
c. Assistive technology	Click or tap here to enter text.	Click or tap here to enter text.
d. Athletics	Click or tap here to enter text.	Click or tap here to enter text.
e. Behavioral health and TBI	Click or tap here to enter text.	Click or tap here to enter text.
f. Caregiving	Click or tap here to enter text.	Click or tap here to enter text.
g. Children and TBI	Click or tap here to enter text.	Click or tap here to enter text.
h. Concussions & mild TBI	Click or tap here to enter text.	Click or tap here to enter text.
i. Criminal justice and TBI	Click or tap here to enter text.	Click or tap here to enter text.
j. Diagnosis	Click or tap here to enter text.	Click or tap here to enter text.
k. Educational issues	Click or tap here to enter text.	Click or tap here to enter text.
l. Employment and training of people with TBI	Click or tap here to enter text.	Click or tap here to enter text.
m. Identification, screening, assessment	Click or tap here to enter text.	Click or tap here to enter text.
n. Independent living	Click or tap here to enter text.	Click or tap here to enter text.
o. Substance Use and TBI	Click or tap here to enter text.	Click or tap here to enter text.
p. Neurobehavioral aspects of TBI	Click or tap here to enter text.	Click or tap here to enter text.
q. Public Policy	Click or tap here to enter text.	Click or tap here to enter text.
r. Person Centered Planning/Counseling	Click or tap here to enter text.	Click or tap here to enter text.
s. Community-based services and support resources	Click or tap here to enter text.	Click or tap here to enter text.
t. Treatment and therapies	Click or tap here to enter text.	Click or tap here to enter text.
u. Other 1(Specify): Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
v. Other 2(Specify): Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
w. Other 3(Specify): Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):
Click or tap here to enter text.

29. Please list and describe any training materials, outreach materials, fact sheets or other products you produced during this reporting period.

Click or tap here to enter text.

30. Is there anything else you would like to let ACL know about your training activities during this reporting period? *This question is not mandatory.*

Click or tap here to enter text.

H. Other (if applicable to grant activities)

31. Describe what activities you undertook in this area this reporting period.

Click or tap here to enter text.

32. How many unduplicated people did you work with or support through the activity identified in 31 during this reporting period? Please enter a number, or select zero or unknown, for each row.

OTHER	NUMBER	ZERO	UNKNOWN
Total number of people who have experienced a TBI who participated in the activity identified in 31	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of people under age 22	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of people between 22-59	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>
Number of people 60 or older	Click or tap here to enter text.	<input type="checkbox"/>	<input type="checkbox"/>

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

Click or tap here to enter text.

List "Other" activities, as needed, in the field below:

I. Narrative Responses (all grantees respond)

33. Please describe the TBI mentoring and work group activities your program led or participated in during this reporting period.

Click or tap here to enter text.

34. Please describe the extent to which the mentoring and work group activities you participated in added value to your program, the national program, and/or any other aspect of your TBI work.

Click or tap here to enter text.

35. Did you use the services of the TBI Technical Assistance and Resource Center (TARC) during this reporting period? [Yes/No] *If yes, please describe these services. If you did not use the services of the TBI TARC during this reporting period, please explain why not.*

Click or tap here to enter text.

36. How would you describe the quality of services you received from the TBI TARC during this reporting period?

Click or tap here to enter text.

37. Is there anything else you would like to let ACL know about your project or the TBI State Partnership Program?

Click or tap here to enter text.

Public Burden Statement:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number (OMB 0985-NEW). Public reporting burden for this collection of information is estimated to average [8] hours per response, including time for gathering and maintaining the data needed and completing and reviewing the collection of information. The obligation to respond to this collection is required to retain or maintain benefits under the statutory authority [Traumatic Brain Injury Reauthorization Act of 2018 (P.L. 115-377)].