



contact@braininjuryalliance.ca

www.braininjuryalliance.ca

FINAL REPORT

August 1, 2020 - July 31, 2021

DUE SEPTEMBER 24th

NOTE: DOWNLOAD REPORT TO YOUR DESKTOP BEFORE FILLING IT IN.

An updated version of Adobe Reader set to open PDF files on your computer is required.
Adobe Reader can be downloaded at: <https://get.adobe.com/reader/>

PRIOR TO BEGINNING THIS REPORT

1. Have your most recent Alliance Interim Report on hand.
2. Have all files for the August 1st - July 31st reporting period on hand.

PAGE 1

SECTION A – GENERAL INFORMATION

Name of Member Agency: _____

Contact Name Responsible for this Report: _____

Contact Phone Number: _____

Contact E-mail Address: _____

Agency Address: _____

Agency City: _____ Postal Code: _____

Brain Injury Alliance Final Report

August 1, 2020 - July 31, 2021 | Page 2



Agency: _____

Report Date (mm/dd/yyyy): _____

SECTION B: PROGRAM REPORTING

SECTION B1 – CLIENT SERVICE PROGRAM 1 FUNDED BY ALLIANCE

Program 1 Name: _____

Program 1 Category: **One to One Services** **Group Services**

1.1 How many unique persons with brain injury were predicted to be served by this program? _____

1.2 How many unique persons with brain injury did the program serve in this 12-month period? _____

1.3. Briefly explain how Alliance funds impacted people this program served: (attach any additional comments)

SECTION B2 – CLIENT SERVICE PROGRAM 2 FUNDED BY ALLIANCE

Program 2 Name: _____

Program 2 Category: **One to One Services** **Group Services**

2.1. How many unique persons with brain injury were predicted to be served by this program? _____

2.2. How many unique persons with brain injury did the program serve in this 12-month period? _____

2.3. Briefly explain how Alliance funds impacted people this program served: (attach any additional comments)

Brain Injury Alliance Final Report

August 1, 2020 - July 31, 2021 | Page 3



Agency: _____

Report Date (mm/dd/yyyy): _____

SECTION B: PROGRAM REPORTING

SECTION B3 – CLIENT SERVICE PROGRAM 3 FUNDED BY ALLIANCE

Program 3 Name: _____

Program 3 Category: **One to One Services** **Group Services**

3.1. How many unique persons with brain injury were predicted to be served by this program? _____

3.2. How many unique persons with brain injury did the program serve in this 12-month period? _____

3.3. Briefly explain how Alliance funds impacted people this program served: (attach any additional comments)

SECTION B4 – CLIENT SERVICE OR COMMUNITY SERVICE PROGRAM 4 FUNDED BY ALLIANCE

Program 4 Name: _____

Program 4 Category: **Injury Prevention** **Community Education** **Client Service**

4.1. What was the projected number of persons this program was expected to serve? _____

4.2. What was the total number of persons the program served during this 12-month period? _____

4.3. Briefly explain how Alliance funds impacted people this program served: (attach any additional comments)

Brain Injury Alliance Final Report

August 1, 2020 - July 31, 2021 | Page 4



Agency: _____

Report Date (mm/dd/yyyy): _____

SECTION C – FINANCIAL REPORT / USE OF ALLIANCE FUNDS

A. How much was the total annual grant that your organization received from the Alliance for these programs during this 12-month grant period (August last year to July this year)? \$ _____

B. How have you allocated funds received?

Program 1 (name) _____ Amount \$ _____

Program 2 (name) _____ Amount \$ _____

Program 3 (name) _____ Amount \$ _____

Program 4 (name) _____ Amount \$ _____

Are program expenditures on-track with allocations? If not, briefly explain: (attach any additional comments)

SECTION D – SOCIAL IMPACTS OF YOUR AGENCY'S SERVICES

a. Did any of the people your agency served obtain employment during this period?

Y N How many? _____ Please list employment type and frequency below.

b. Did any of your agency's services reduce client involvement with medical/hospital services?

Y N How many? _____ Please list type and how:

c. Did any of your agency's services reduce client involvement with the justice system?

Y N How many? _____ Please list type and how:

d. Did your agency provide training/education about acquired brain injury and resources to:

Corrections BC Staff: Y N Inmates: Y N

Brain Injury Alliance Final Report

August 1, 2020 - July 31, 2021 | Page 5



Agency: _____

Report Date (mm/dd/yyyy): _____

SECTION E – IMPACT OF ALLIANCE FUNDING

As a result of Alliance funding between **2020 to 2021**, which of the following apply (choose yes or no):

Agency Capacity / Continuity

Yes	No	Maintained Programs/Services
Yes	No	Increased Programs/Services
Yes	No	Increased New Client Intakes
Yes	No	Maintained # of Clients Served
Yes	No	Increased # of Clients Served

Employee Retention & Development

Yes	No	Low Staff Turnover
Yes	No	Increased # of Staff
Yes	No	Provided Staff Training

Provided Injury Prevention Programs

Yes	No	Sporting Teams/Events
Yes	No	Community Events
Yes	No	Community Groups
Yes	No	Schools Grade 1-12
Yes	No	Post-secondary
Yes	No	Other (please describe):

Worked Closely With and/or Developed Partnerships with Stakeholders

Yes	No	Physicians
Yes	No	Hospitals
Yes	No	Allied Health Professionals
Yes	No	Health Authorities
Yes	No	Schools Grade 1-12 (<i>supported</i> a client or a client's instructors/teachers)
Yes	No	Schools Grade 1-12 (provided <i>education</i> to students about the effects of brain injuries)
Yes	No	Post-secondary (<i>supported</i> a client or a client's instructors/teachers)
Yes	No	Post-secondary (provided <i>education</i> to students about the effects of brain injuries)
Yes	No	Employers (<i>supported</i> a client or a client's colleague/manager)
Yes	No	Employers (provided <i>education</i> to workers about the effects of brain injury)
Yes	No	Transit
Yes	No	WorkSafe BC
Yes	No	Other (please describe):

Brain Injury Alliance Final Report

August 1, 2020 - July 31, 2021| Page 6



Agency: _____

Report Date (mm/dd/yyyy): _____

SECTION F – FINANCIAL REPORT / USE OF ALLIANCE FUNDS

SECTION F1– FINANCIAL REPORT / USE OF ALLIANCE FUNDS

Program 1 Name

REVENUE (describe in comments section)	BUDGET	ACTUAL	COMMENTS
ALLIANCE			
HEALTH AUTHORITY			
GAMING			
FUNDRAISING & GRANTS			
OTHER			
TOTAL			
EXPENSES (describe in comments section)			
WAGES & BENEFITS			
SUPPLIES			
EXTERNAL FACILITATORS/CONTRACTORS ETC			
FACILITY COSTS (max 10% of revenue)			
ADMINISTRATION (max 10% of revenue)			
TOTAL			
SURPLUS/DEFICIT			

If you had no funding from the ALLIANCE would your agency have been able to offer this program? Yes No

If yes, but at a reduced capacity, how would you have managed this?

COMMENTS

Stricter screening of clients Y N

Eliminate some components of the service Y N

Reduce hours of staff availability Y N

Reduce the frequency of program Y N

Charge a user fee Y N

Other (please describe) _____

We gratefully acknowledge the financial assistance of the Province of British Columbia

Brain Injury Alliance Final Report

August 1, 2020 - July 31, 2021 | Page 7



Agency: _____

Report Date (mm/dd/yyyy): _____

SECTION F – FINANCIAL REPORT / USE OF ALLIANCE FUNDS

SECTION F2 – FINANCIAL REPORT / USE OF ALLIANCE FUNDS

Program 2 Name

REVENUE (describe in comments section)	BUDGET	ACTUAL	COMMENTS
ALLIANCE			
HEALTH AUTHORITY			
GAMING			
FUNDRAISING & GRANTS			
OTHER			
TOTAL			
EXPENSES (describe in comments section)			
WAGES & BENEFITS			
SUPPLIES			
EXTERNAL FACILITATORS/CONTRACTORS ETC			
FACILITY COSTS (max 10% of revenue)			
ADMINISTRATION (max 10% of revenue)			
TOTAL			
SURPLUS/DEFICIT			

If you had no funding from the ALLIANCE would your agency have been able to offer this program? Yes No

If yes, but at a reduced capacity, how would you have managed this?

COMMENTS

Stricter screening of clients	Y	N
Eliminate some components of the service	Y	N
Reduce hours of staff availability	Y	N
Reduce the frequency of program	Y	N
Charge a user fee	Y	N
Other (please describe)		

We gratefully acknowledge the financial assistance of the Province of British Columbia

Brain Injury Alliance Final Report

August 1, 2020 - July 31, 2021 | Page 8



Agency: _____

Report Date (mm/dd/yyyy): _____

SECTION F – FINANCIAL REPORT / USE OF ALLIANCE FUNDS

SECTION F3 – FINANCIAL REPORT / USE OF ALLIANCE FUNDS

Program 3 Name

REVENUE (describe in comments section)	BUDGET	ACTUAL	COMMENTS
ALLIANCE			
HEALTH AUTHORITY			
GAMING			
FUNDRAISING & GRANTS			
OTHER			
TOTAL			
EXPENSES (describe in comments section)			
WAGES & BENEFITS			
SUPPLIES			
EXTERNAL FACILITATORS/CONTRACTORS ETC			
FACILITY COSTS (max 10% of revenue)			
ADMINISTRATION (max 10% of revenue)			
TOTAL			
SURPLUS/DEFICIT			

If you had no funding from the ALLIANCE would your agency have been able to offer this program? Yes No

If yes, but at a reduced capacity, how would you have managed this?

COMMENTS

Stricter screening of clients Y N

Eliminate some components of the service Y N

Reduce hours of staff availability Y N

Reduce the frequency of program Y N

Charge a user fee Y N

Other (please describe) _____

We gratefully acknowledge the financial assistance of the Province of British Columbia

Brain Injury Alliance Final Report

August 1, 2020 - July 31, 2021 | Page 9



Agency: _____

Report Date (mm/dd/yyyy): _____

SECTION F – FINANCIAL REPORT / USE OF ALLIANCE FUNDS

SECTION F4 – FINANCIAL REPORT / USE OF ALLIANCE FUNDS

Program 4 Name

REVENUE (describe in comments section)	BUDGET	ACTUAL	COMMENTS
ALLIANCE			
HEALTH AUTHORITY			
GAMING			
FUNDRAISING & GRANTS			
OTHER			
TOTAL			
EXPENSES (describe in comments section)			
WAGES & BENEFITS			
SUPPLIES			
EXTERNAL FACILITATORS/CONTRACTORS ETC			
FACILITY COSTS (max 10% of revenue)			
ADMINISTRATION (max 10% of revenue)			
TOTAL			
SURPLUS/DEFICIT			

If you had no funding from the ALLIANCE would your agency have been able to offer this program? Yes No

If yes, but at a reduced capacity, how would you have managed this?

COMMENTS

Stricter screening of clients	Y	N
Eliminate some components of the service	Y	N
Reduce hours of staff availability	Y	N
Reduce the frequency of program	Y	N
Charge a user fee	Y	N
Other (please describe)		

We gratefully acknowledge the financial assistance of the Province of British Columbia

Brain Injury Alliance Final Report

August 1, 2020- July 31, 2021 | Page 10



Agency: _____

Report Date (mm/dd/yyyy): _____

SECTION G – STORY OF BENEFIT FROM ALLIANCE FUNDING

Please share ONE story about an individual or family that has benefited from Alliance funded services. **Maximum 250 words.** Please ensure that the individual consents to share their story.

Submit a signed authorization form (included on following page) from the individual that grants the Alliance permission to use this story and any photographs related to this person.

You may also share a story about the social impacts of Alliance funding (refer to Section D) as your success story, or as an additional story.

Please attach copies of current brochures or program material that are relevant to the work that was funded in whole, or in part, by the Alliance.

If you have any questions, contact the Brain Injury Alliance at: contact@braininjuryalliance.ca

We gratefully acknowledge the financial assistance of the Province of British Columbia

Brain Injury Alliance

ARTICLE, IMAGE & DIGITAL MEDIA CONSENT FORM



for story submitted with Final Report 2020/2021 Annual Grant

WHEREAS the Alliance is a province wide organization in British Columbia working to improve the quality of life of persons living with a brain injury, their families and their community.

WHEREAS the Alliance from time to time collects and publishes articles, photographs, images, and audio recordings for the purpose of encouraging public awareness and understanding of the lives of persons living with a brain injury and obtaining funding.

I hereby give the Alliance, its representatives and employees, permission to use and/or reproduce all digital media taken of, or including me, and/or information gathered about or including me by the Alliance or by any nominee of the Alliance, including any agency, clients, publication or other organization or institution, in all forms of media, for distribution to the general public for the purposes of publicity and promotion of the Alliance (the "Digital Media").

I further consent to the reproduction or use of the Digital Media with or without my name, and consent that the Alliance may seek copyright of the Digital Media in their name. I understand and agree that the Digital Media will become property of the Alliance and may not be returned.

I hereby release and hold harmless the Alliance and its nominees from all liability which I, my heirs, representatives, executors, administrators, or any other person acting on my behalf may have for any violation of any personal or proprietary right I may have in connection with the Digital Media.

I affirm that I am at least 19 years of age, or if I am under 19 years of age, I have obtained the required consent of my parents/legal guardians as evidenced by the signatures below.

Signed this _____ day of _____, 20_____.

Client Name (please print)

Name of Client's Brain Injury Agency

Signature

Name of Parent/Guardian (please print) [If under 19 years]

Telephone Number