NJ Department of Human Services
Division of Disability Services

TRAUMATIC BRAIN INJURY FUND:
APPLICATION

INSTRUCTIONS: Complete the application below and sign it to be considered for eligibility to the Traumatic Brain Injury Fund. All required fields must be completed before the application can be submitted. Additionally, once you have submitted your application, your healthcare provider will need to complete and sign the Medical Form. Your completed application will be reviewed and you will be notified of your eligibility. You may contact us at 1-888-285-3036, prompt #1 for questions or assistance with completing the application.

Please note: Power of Attorney and legal guardians should include paperwork to verify such status at the time of the application.

*Items in **RED** are required fields.*

First Name | Middle Initial | Last Name

Address

City | State | Zip

Email

Phone | Date of Birth

Preferred Method of Communication

☐ Verbal ☐ Written ☐ Verbal with written follow-up

Person filling out form, if different from Applicant:

First Name | Middle Initial | Last Name

Address

City | State | Zip

Email | Phone

Demographic Information

Marital Status

☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Gender Identity

☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary
☐ Prefer not to say

Race

☐ Black or African American ☐ Asian American ☐ Indian or Alaskan Native ☐ Native Hawaiian
☐ White ☐ Prefer not to say

Ethnicity

☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to say

Level of Education

☐ Some High School ☐ High School ☐ Trade School ☐ Associate's Degree
☐ Bachelor's Degree ☐ Doctoral Degree ☐ Prefer not to say

Do you have dependent children? ☐ Yes ☐ No

Employment Status

☐ Employed Part-time ☐ Employed Full-time ☐ Seeking Opportunities ☐ Retired
☐ On Disability ☐ Not Employed

What is your living situation?

☐ Private Home ☐ Hospital ☐ Assisted Living ☐ Independent Living Facility
☐ Nursing Facility ☐ Group Home

Medical Information

Date of Brain Injury Cause of Brain Injury
Treatment Received for Injury

Financial Information

Annual Income (All Sources) $
Have you received a settlement or civil judgment based on the injury? ☐ Yes ☐ No

Type of Settlement

☐ Settlement ☐ Civil Judgement

Docket Number Amount of settlement $

Attorney Name
Attorney Email Attorney Phone
Attorney Address

Types of Insurance

☐ Private ☐ SSI ☐ Medicare ☐ Medicaid ☐ MLTSS ☐ None ☐ Other

Other, please explain

Do you have liquid assets $100,000 or more?

"Liquid assets" are assets that are convertible to cash within 30 days. Liquid assets for the applicant or his or her immediate family include checking and savings accounts, stocks, bonds, treasury notes and similar instruments. The home where the Applicant lives, vehicles, and personal property are not considered liquid assets. For applicants 18 years or younger, liquid assets of the parent(s)/guardian(s) will be considered.

☐ Yes ☐ No

Savings Amount ($) Checking Amount ($)

Stock/Bonds Income ($) Other Income ($)

Other Assets

Current Services

Other Programs enrolled in with the NJ Department of Human Services

List (check all) ☐ PASP ☐ DDD ☐ Medicaid ☐ JACC

Other Services

Any service or support available to the general public through a governmental program or agency (i.e. VA, Worker's compensation)

I understand the information I give is subject to verification. I give permission to the Division of Disability Services and its agents/contractors to contact individuals or other sources that may have knowledge about my circumstances necessary for this application. I give third parties permission to share information about me with authorized State and State contractor staff to assist with this application, enrollment and administration. I give permission for the TBI Fund Review Committee to review all information necessary to render decisions regarding my application and request for services. I understand that I must sign the attached release for medical documentation in order for my application to be processed. I understand that I may not have more than $100,000 in liquid resources. I understand that I must provide any updates and changes to any information provided on this application including but not limited to, my residence, other health insurance coverage, changes in resources and the filing or outcome of lawsuits. I understand that the TBI Fund has a legal right to be reimbursed for services from any monies received as a result of a settlement, judgement or other payment stemming from the traumatic brain injury. ☐ Yes

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508 I agree to the release of the medical information below to the Traumatic Brain Injury Fund for the purposes of determining eligibility. I understand that the TBI Fund reserves the right to contact listed physician for clarification of this information, and that medical information is protected under the Health Insurance Portability and Accountability Act (HIPAA). ☐ Yes

By signing below, I certify that the information provided is true, correct and complete to the best of my knowledge. I also certify that I have read and understand my responsibilities under this program.

_____ _____

Signature **Date**

Please send completed signed application to:

NJ Department of Human Services
Division of Disability Services
TBI Fund
PO Box 705
Trenton, NJ 08625-0705