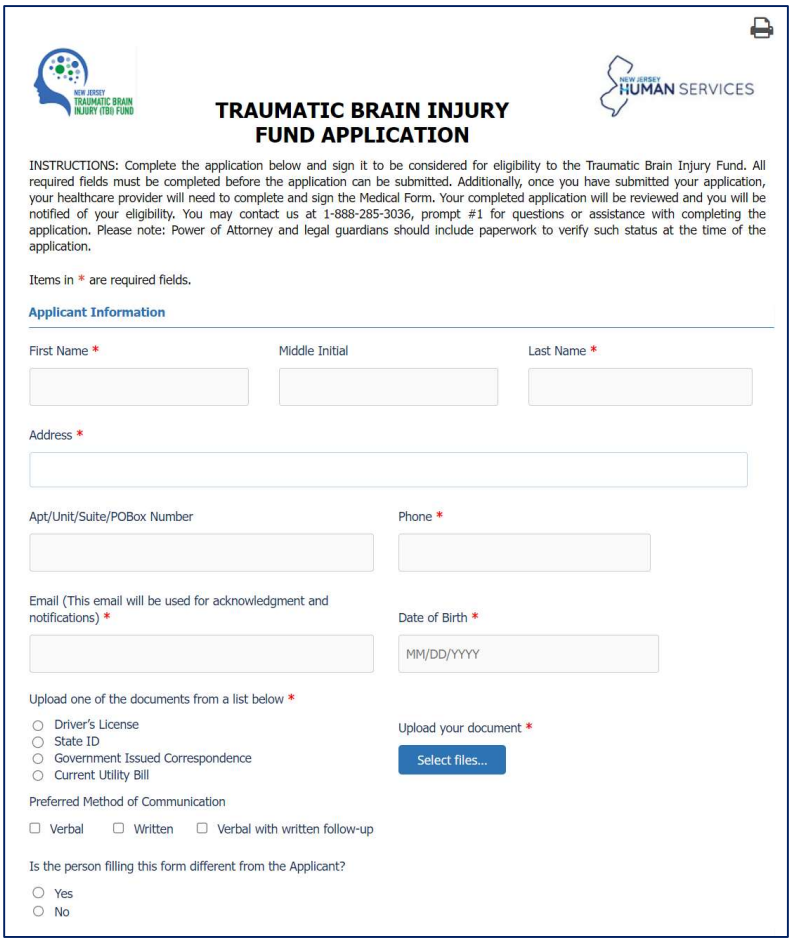
TBI Application Process

The following guide explains how to fill in the TBI Fund Application.

1. Navigate to the following link: njdhs.prod.simpligov.com/prod/portal/ShowWorkFlow/AnonymousEmbed/a880110f-dd71-4b13-ae5b-65772ca565aa
   The following form is displayed:



NEW JERSEY TRAUMATIC BRAIN INJURY (TBI) FUND

NEW JERSEY HUMAN 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 * are required fields.

Applicant Information

First Name * | Middle Initial | Last Name *

Address *

Apt/Unit/Suite/POBox Number | Phone *

Email (This email will be used for acknowledgment and notifications) * | Date of Birth *

MM/DD/YYYY

Upload one of the documents from a list below *

- Driver's License
- State ID
- Government Issued Correspondence
- Current Utility Bill

Upload your document *

Select files...

Preferred Method of Communication

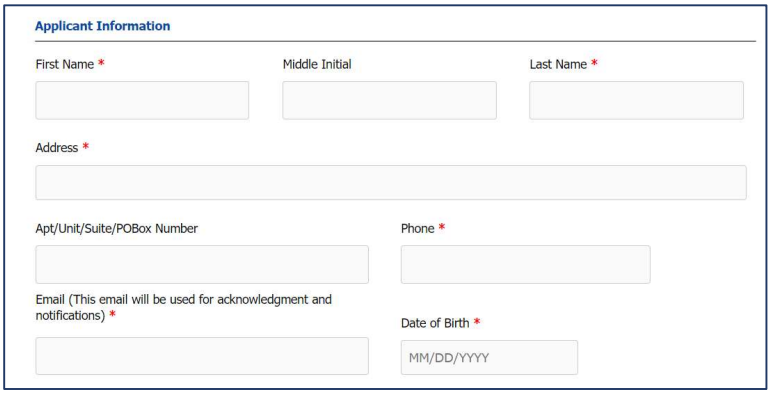
Verbal | Written | Verbal with written follow-up

Is the person filling this form different from the Applicant?

- Yes
- No

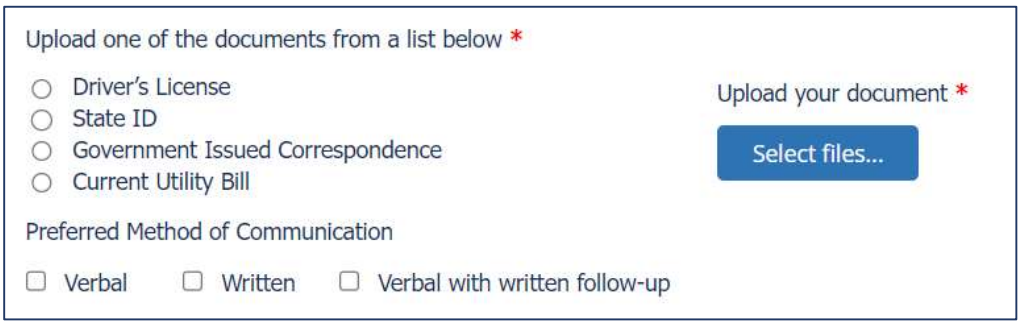
Applicant Information

1. Enter the required information.

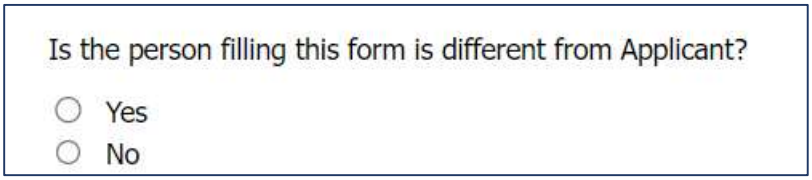


2. Select the required and relevant information.
3. Attach your documents by selecting, **Select files..**

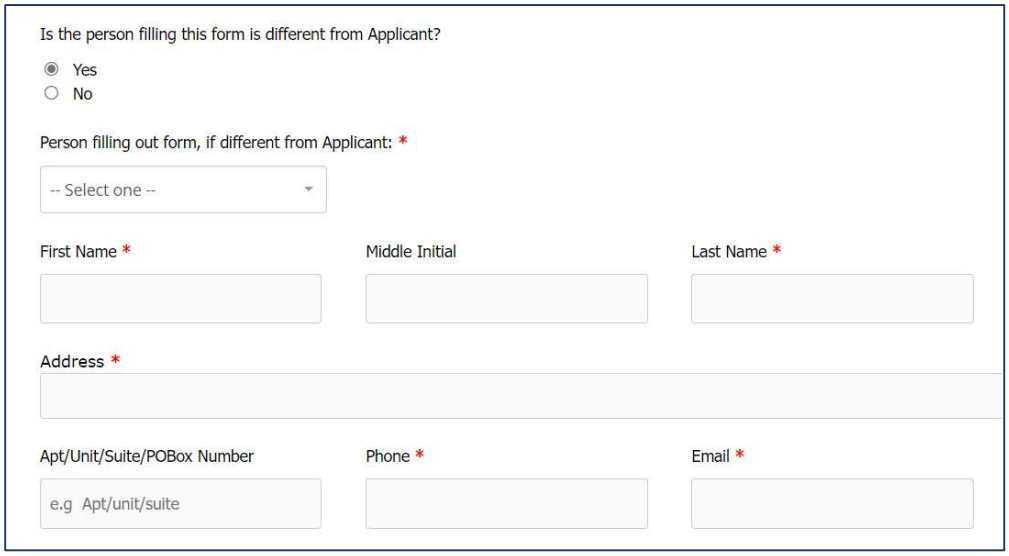
Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document, one at a time.



4. Select **Yes**, or **No**.

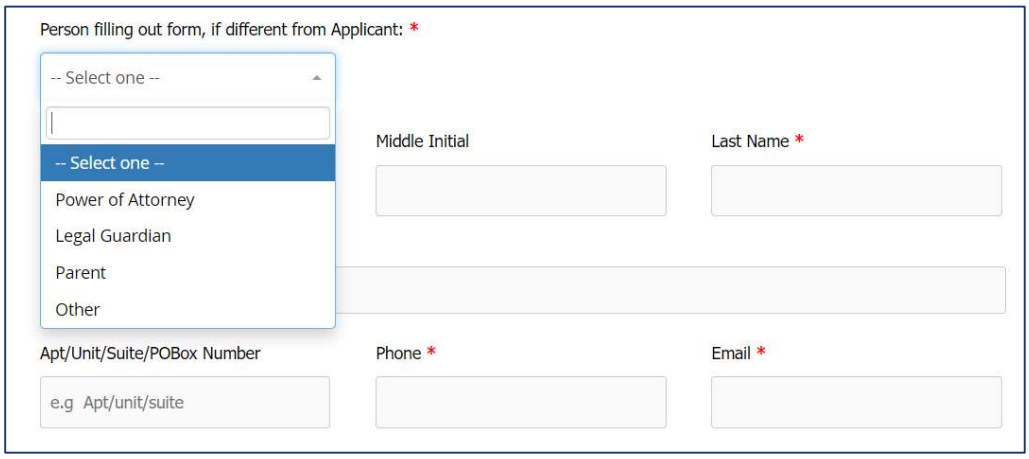


Note: If you selected Yes, an additional section opens. Please follow the process starting at section 2a.



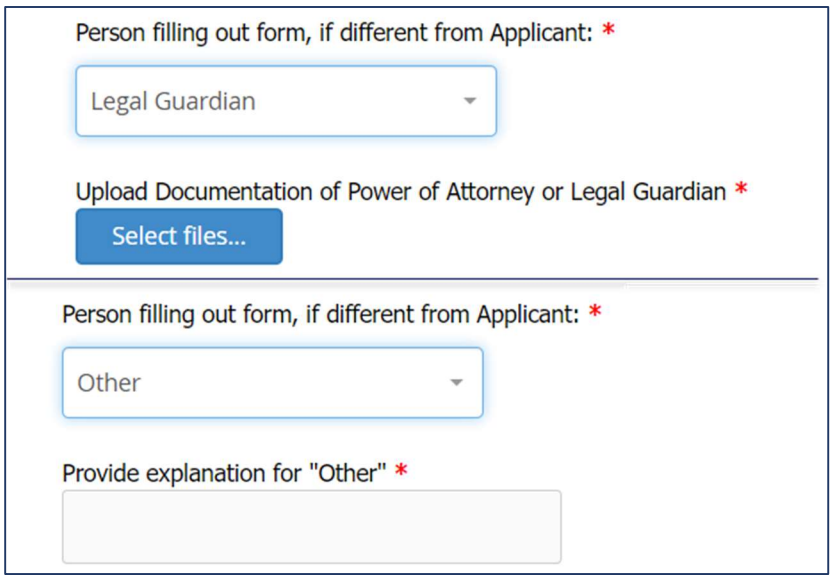
Section 2a

2a Select an option from the drop-down menu.

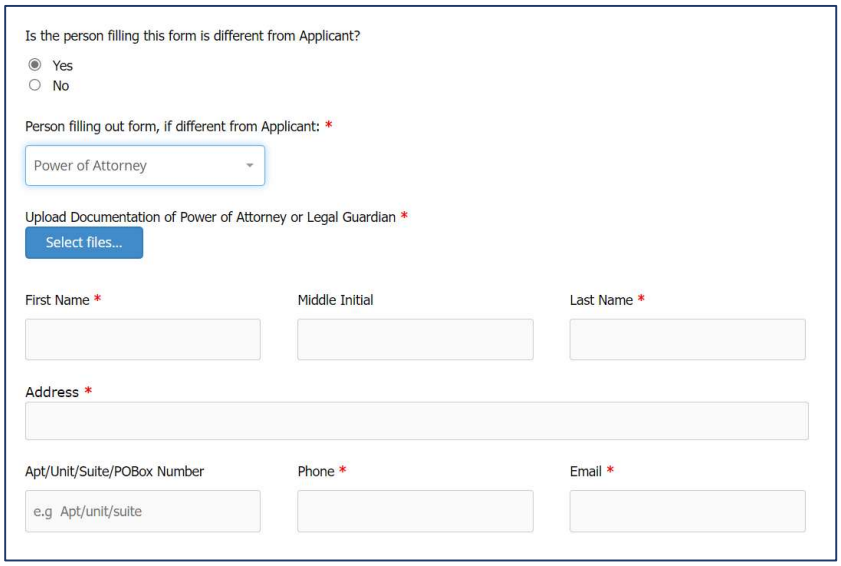


Note: If you select Legal Guardian or Power of Attorney you have to attach a file. If you select Other an additional field is displayed.

Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document, one at a time.

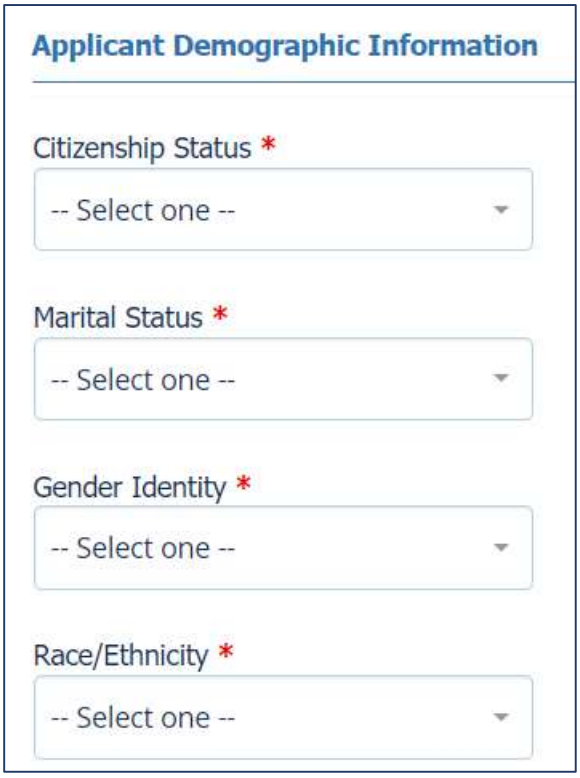


2b Enter the required and relevant information.



Applicant Demographic Information

1. Select your answers from the following drop-down menus.



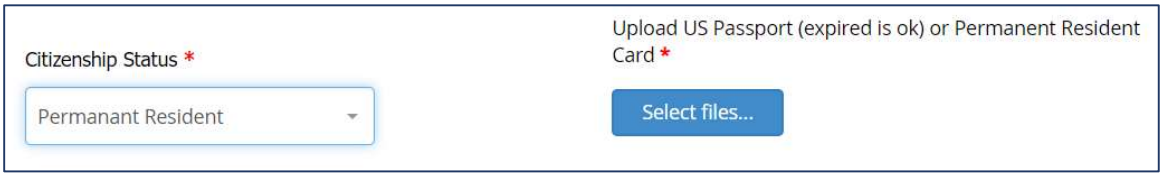
Note: Additional information is required if you selected Naturalized or Derived Citizen (born outside of the US), or Permanent Resident.

Note: For Naturalized or Derived Citizen (born outside of the US). Please select the Certificate Type. Please provide the required information.

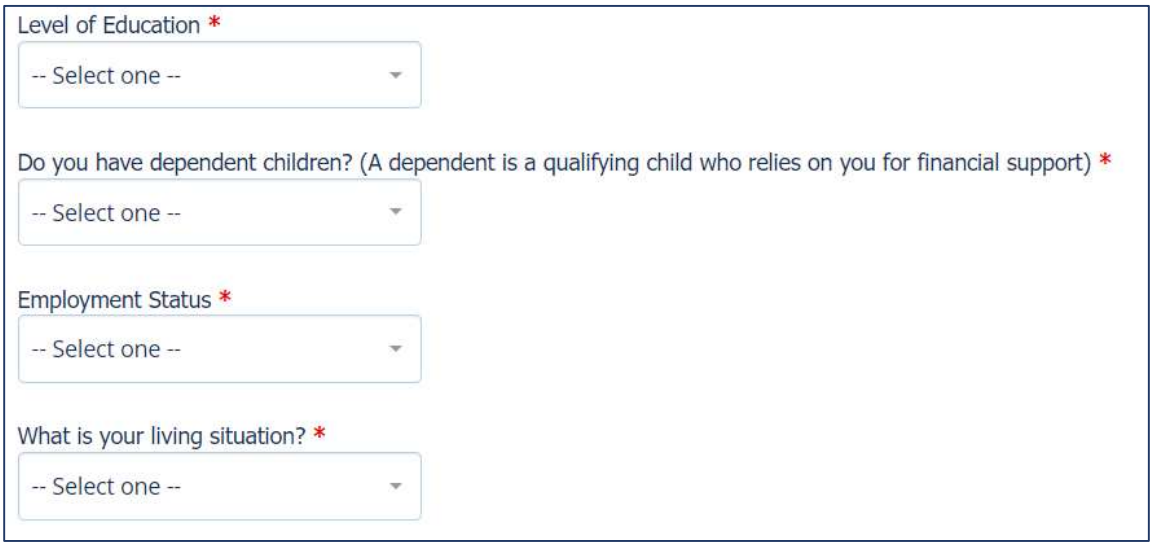
Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document, one at a time.

For Permanent Resident please provide the required document.

Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document, one at a time.



2. Select your answers from the following drop-down menus.



Note: Additional options are displayed if you selected Private Home from the drop-down menu.

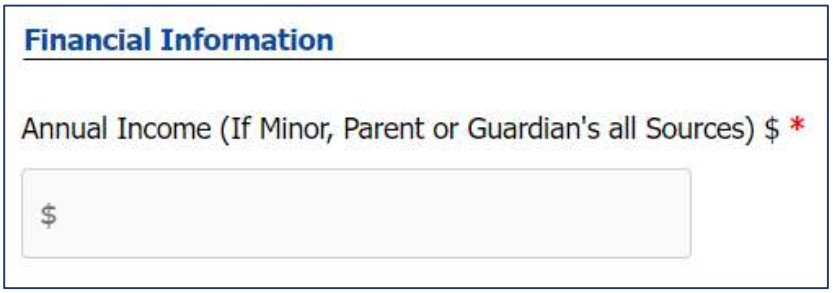
Medical Information

1. Select the **Year of Injury (yyyy)**.

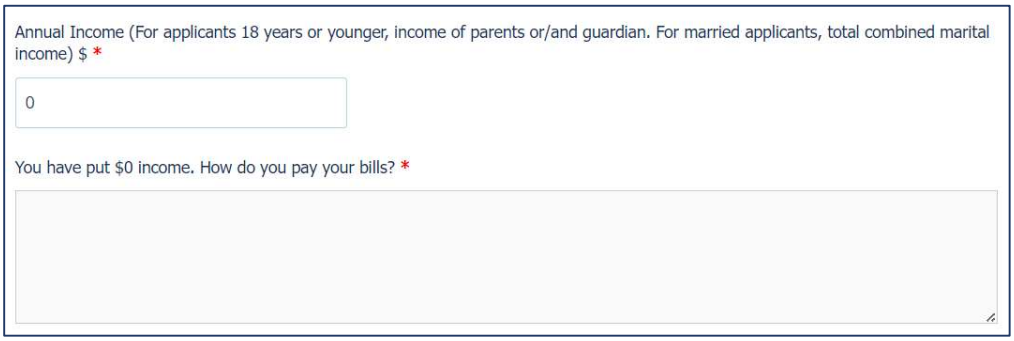
2. Enter the required and relevant information for the remaining fields.

Financial Information

1. Enter your **Annual Income**.

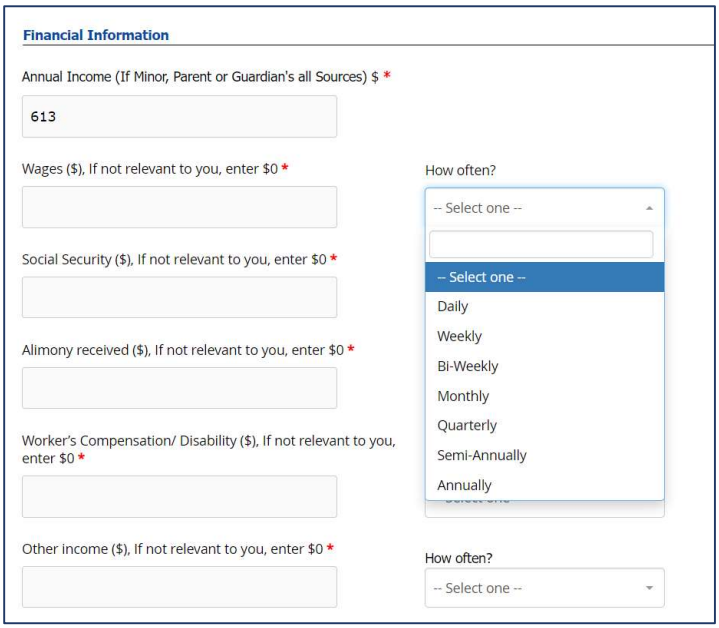


If you entered 0 Annual Income, please attach a file explaining how you pay your bills.

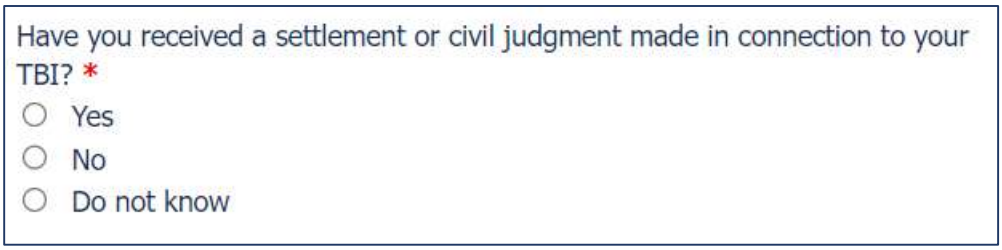


2. Enter your **Annual Income**.
3. Enter the required information and relevant information.

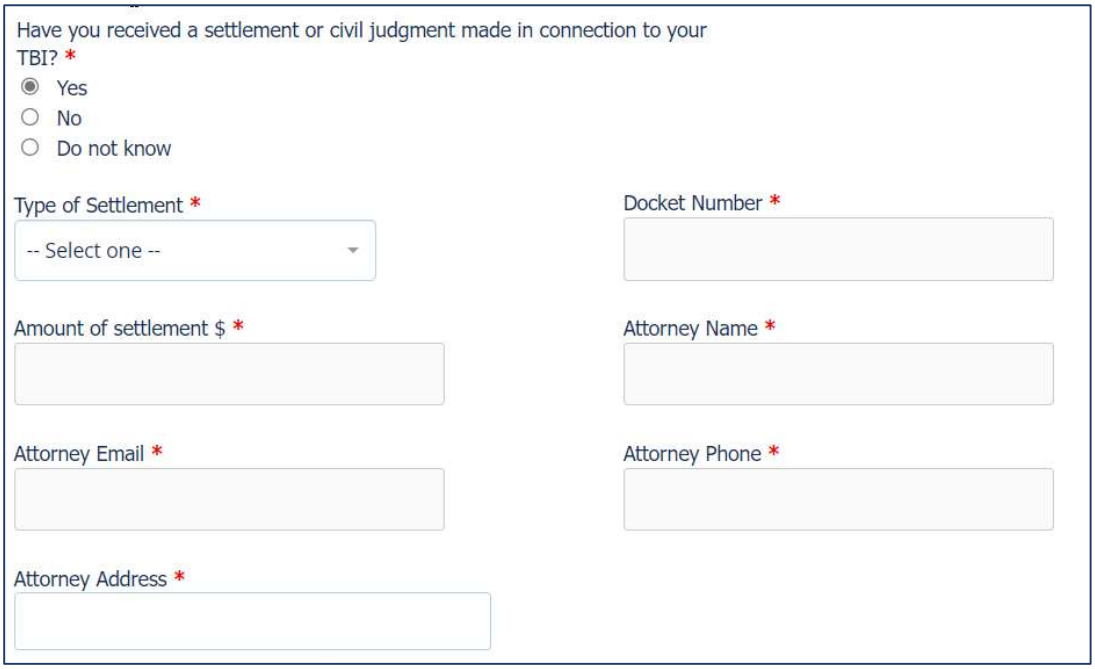
Note: Once you have entered your Annual Income, please answer the following questions. If a question is not relevant to you, please enter 0. If relevant, please select an answer from the How often? drop-down menu.



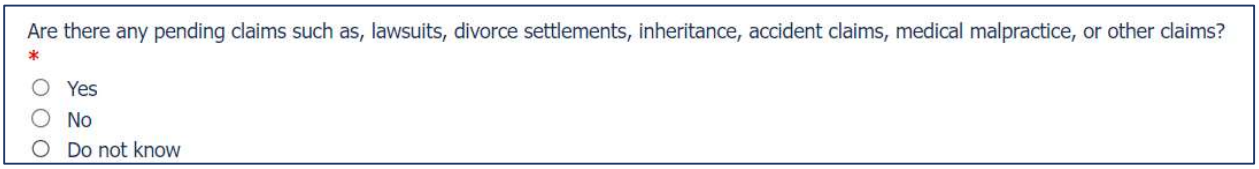
4. Select **Yes**, **No, or Do not know**.



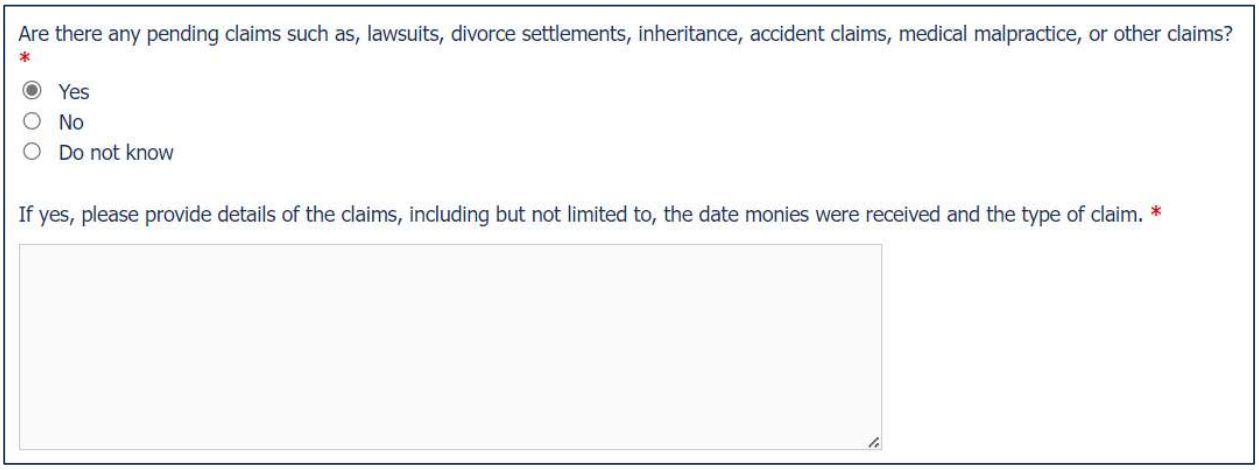
Note: If you selected Yes, an additional section is displayed. Please select and enter the required information.



5. Select **Yes, No, or Do not know**.



Note: If you select Yes, you have to provide an explanation.



6. Select **Yes**, or **No**.

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. Individual and jointly held assets of married couples will be considered. "Immediate family" is defined as: Biological or adoptive parent(s) or other persons who have been legally determined to be financially responsible for an applicant/beneficiary who is under the age of 18 or Persons who have been legally determined to be financially responsible for an applicant/beneficiary who is over the age of 18, including a legally recognized partner. *

- ○ Yes
- ○ No

Savings Amount ($) *

$

Additional saving account

- ○ Yes
- ○ No

Checking Amount ($) *

$

Additional checking account

- ○ Yes
- ○ No

Additional checking account

- ○ Yes
- ○ No

Stocks/Bonds ($)

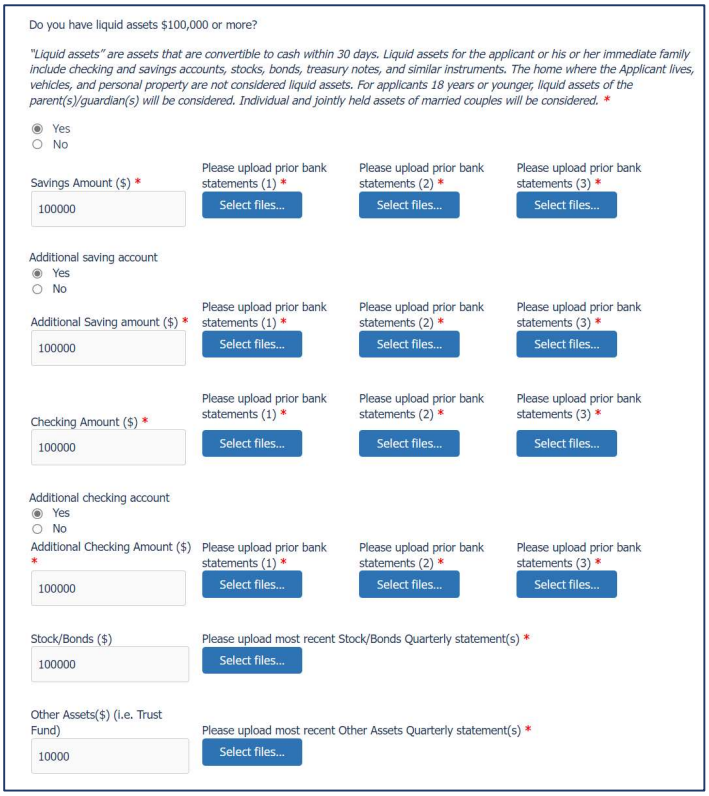
$

Other Assets($) (i.e. Trust Fund)

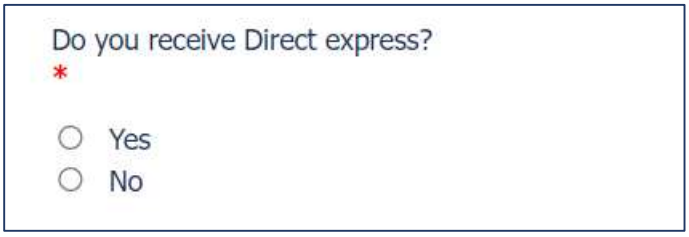
$

Note: If you entered an amount that is more than 0, please attach the required files by selecting Select files…

Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document, one at a time.

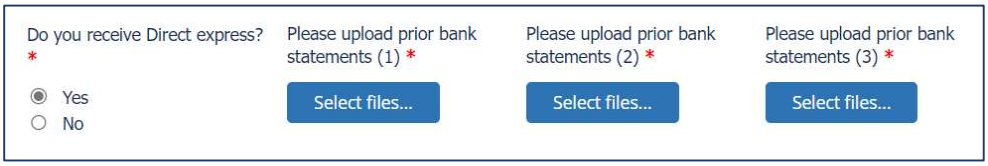


7. Select **Yes** or, **No**.

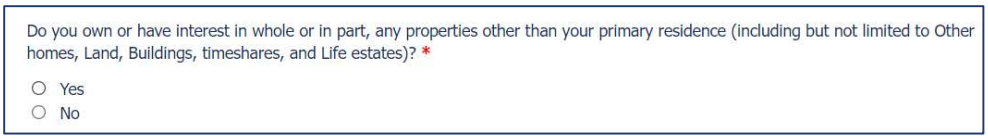


Note: If you select Yes, please add the required documents by selecting, Select files…

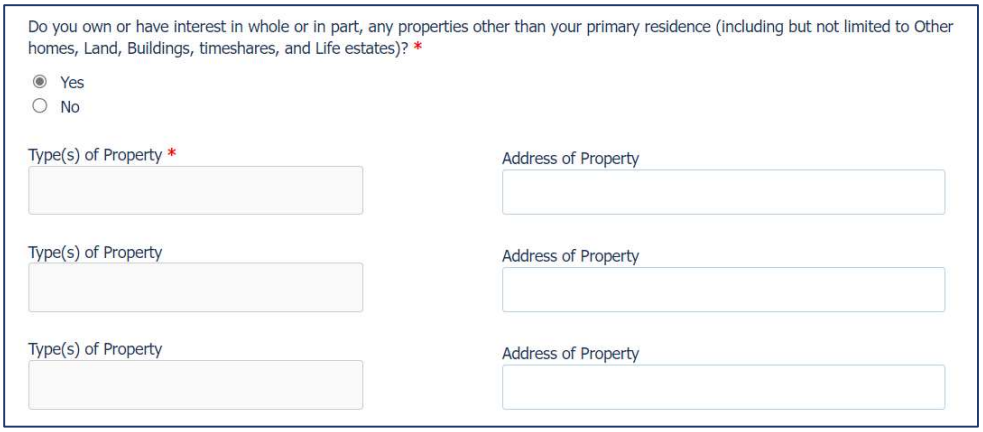
Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document, one at a time.



8. Select **Yes** or, **No**.

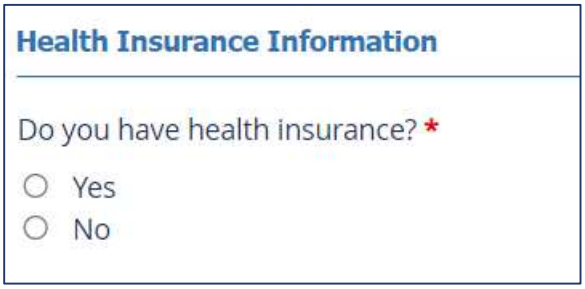


Note: If you select Yes, please add the required and relevant information.

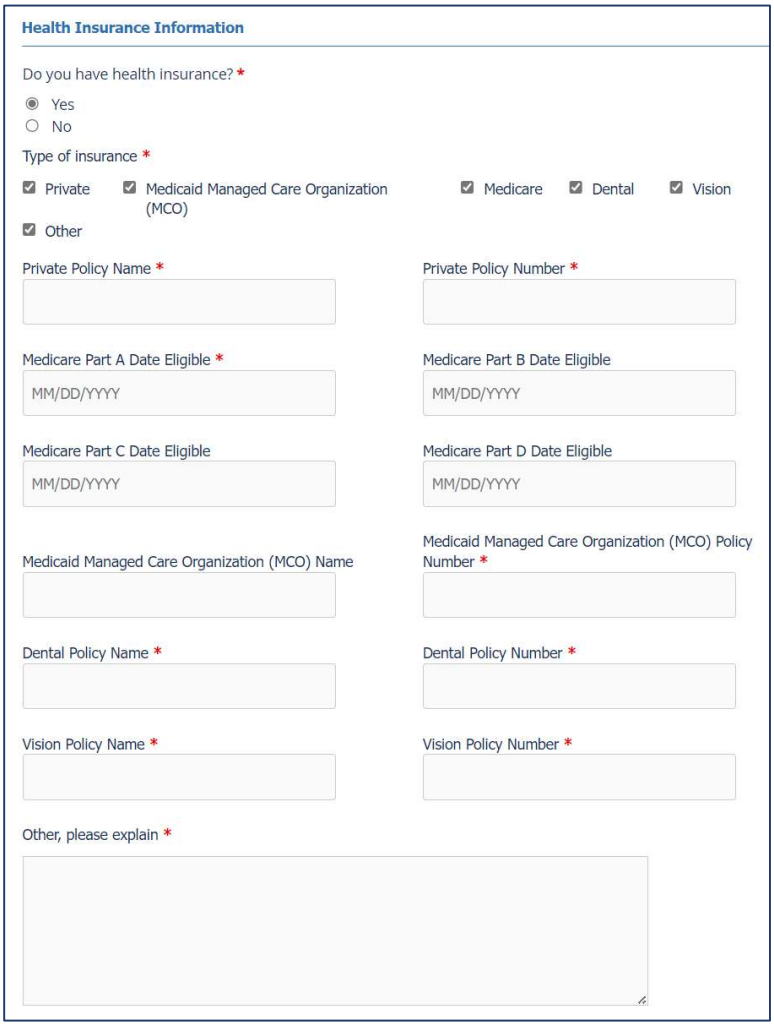


Health Insurance Information

1. Select **Yes**, or **No**.

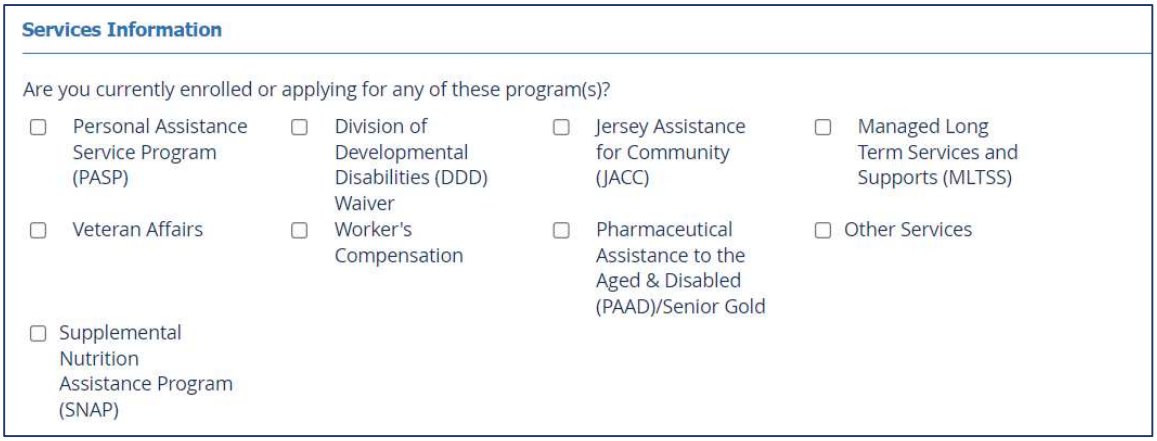


Note: By selecting Yes, you have to select a Type of Insurance-CB. You only have to select your own insurance. The screenshot below is only meant to be an example. Please enter the required details relating to your insurance policy.



Services Information

1. Select any public programs you are enrolled in.

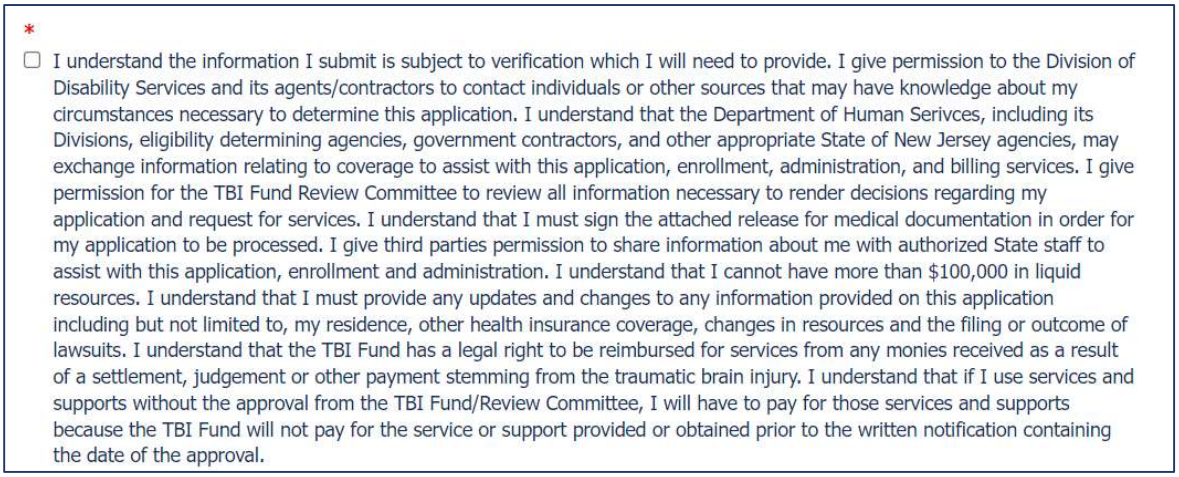


Services Information

Are you currently enrolled or applying for any of these program(s)?

- ☐ Personal Assistance Service Program (PASP)
- ☐ Division of Developmental Disabilities (DDD) Waiver
- ☐ Jersey Assistance for Community (JACC)
- ☐ Managed Long Term Services and Supports (MLTSS)
- ☐ Veteran Affairs
- ☐ Worker's Compensation
- ☐ Pharmaceutical Assistance to the Aged & Disabled (PAAD)/Senior Gold
- ☐ Other Services
- ☐ Supplemental Nutrition Assistance Program (SNAP)

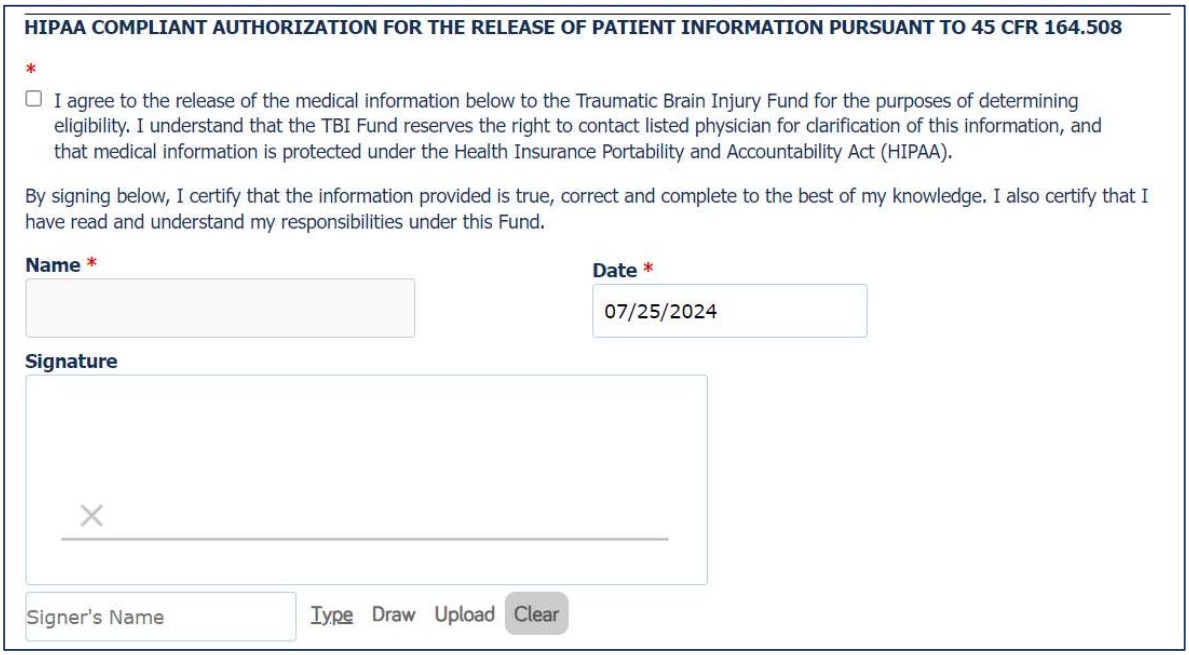
2. Read the paragraph carefully and select the box.



*

☐ I understand the information I submit is subject to verification which I will need to provide. 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 to determine this application. I understand that the Department of Human Serivces, including its Divisions, eligibility determining agencies, government contractors, and other appropriate State of New Jersey agencies, may exchange information relating to coverage to assist with this application, enrollment, administration, and billing services. 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 give third parties permission to share information about me with authorized State staff to assist with this application, enrollment and administration. I understand that I cannot 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. I understand that if I use services and supports without the approval from the TBI Fund/Review Committee, I will have to pay for those services and supports because the TBI Fund will not pay for the service or support provided or obtained prior to the written notification containing the date of the approval.

3. Read the **HIPAA** statement carefully. Select the box once you have completed reading and agreed to the statement.
4. Enter your **Name** and **Date**.
5. **Type**, **Draw**, or **Upload** your **Signature**.



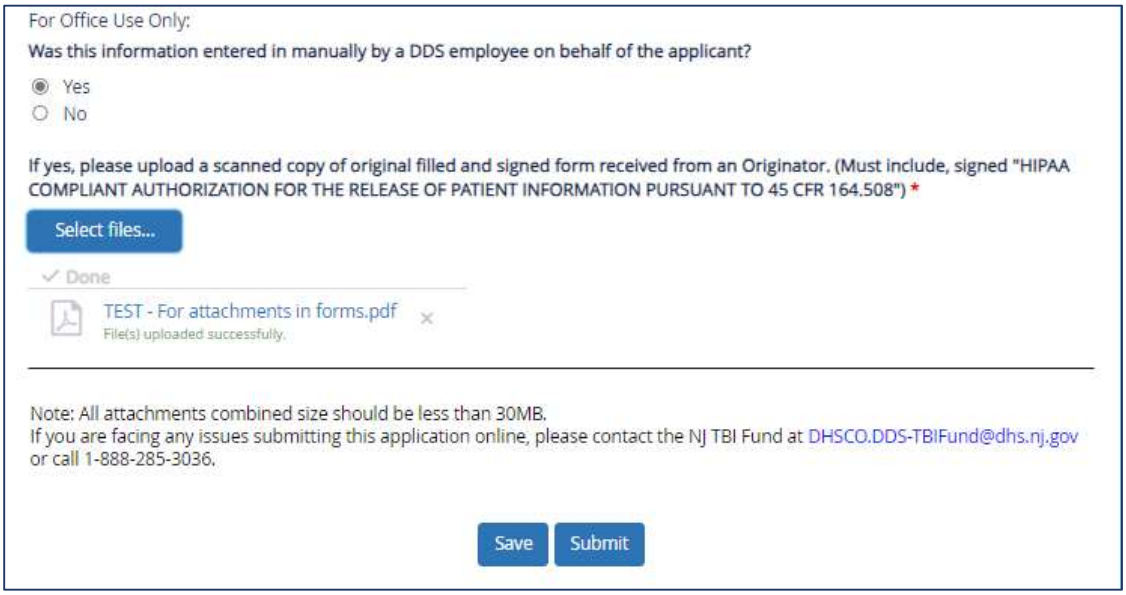
6. Enter the required information.

Note: If your email does not match in the Confirm Your Healthcare Provider Email field, the message "Emails must match" is displayed. You have to confirm email to submit the form.

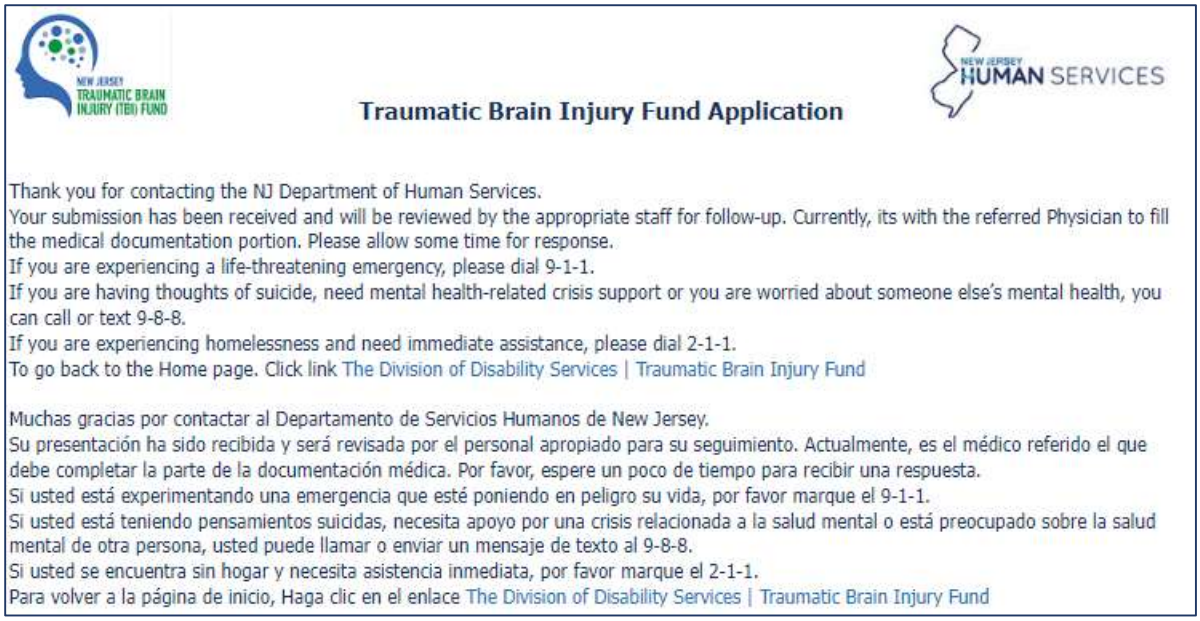
7. Select **Yes**, or **No.**
8. Select **Save** if you would like to come back to the form at a later time.
   Select **Submit** once you are ready to complete the form.

Note: If you selected Yes, attach the manual form by selecting, Select files…

Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document, one at a time.



Once submitted this message is displayed:



Traumatic Brain Injury Fund Application

Thank you for contacting the NJ Department of Human Services.
Your submission has been received and will be reviewed by the appropriate staff for follow-up. Currently, its with the referred Physician to fill the medical documentation portion. Please allow some time for response.
If you are experiencing a life-threatening emergency, please dial 9-1-1.
If you are having thoughts of suicide, need mental health-related crisis support or you are worried about someone else's mental health, you can call or text 9-8-8.
If you are experiencing homelessness and need immediate assistance, please dial 2-1-1.
To go back to the Home page. Click link The Division of Disability Services | Traumatic Brain Injury Fund

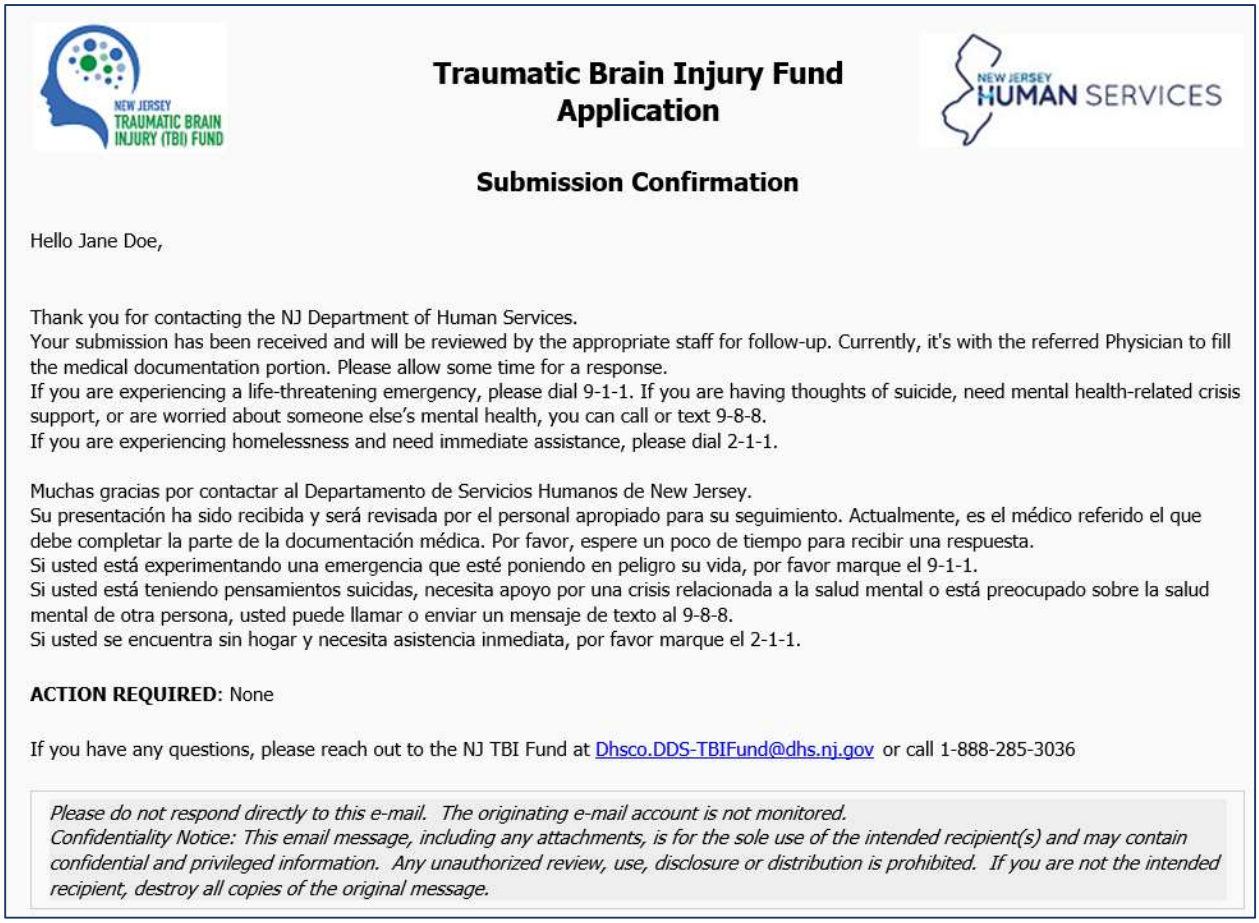
Muchas gracias por contactar al Departamento de Servicios Humanos de New Jersey.
Su presentación ha sido recibida y será revisada por el personal apropiado para su seguimiento. Actualmente, es el médico referido el que debe completar la parte de la documentación médica. Por favor, espere un poco de tiempo para recibir una respuesta.
Si usted está experimentando una emergencia que esté poniendo en peligro su vida, por favor marque el 9-1-1.
Si usted está teniendo pensamientos suicidas, necesita apoyo por una crisis relacionada a la salud mental o está preocupado sobre la salud mental de otra persona, usted puede llamar o enviar un mensaje de texto al 9-8-8.
Si usted se encuentra sin hogar y necesita asistencia inmediata, por favor marque el 2-1-1.
Para volver a la página de inicio, Haga clic en el enlace The Division of Disability Services | Traumatic Brain Injury Fund

Note: Select the links to learn more about the Division of Disability Services.

Emails to the Requester

The following email notifications keep you updated on your form.

An email notification is sent to the requester, notifying them that their Healthcare Provider is currently reviewing the form.



Traumatic Brain Injury Fund Application

Submission Confirmation

Hello Jane Doe,

Thank you for contacting the NJ Department of Human Services.
Your submission has been received and will be reviewed by the appropriate staff for follow-up. Currently, it's with the referred Physician to fill the medical documentation portion. Please allow some time for a response.
If you are experiencing a life-threatening emergency, please dial 9-1-1. If you are having thoughts of suicide, need mental health-related crisis support, or are worried about someone else's mental health, you can call or text 9-8-8.
If you are experiencing homelessness and need immediate assistance, please dial 2-1-1.

Muchas gracias por contactar al Departamento de Servicios Humanos de New Jersey.
Su presentación ha sido recibida y será revisada por el personal apropiado para su seguimiento. Actualmente, es el médico referido el que debe completar la parte de la documentación médica. Por favor, espere un poco de tiempo para recibir una respuesta.
Si usted está experimentando una emergencia que esté poniendo en peligro su vida, por favor marque el 9-1-1.
Si usted está teniendo pensamientos suicidas, necesita apoyo por una crisis relacionada a la salud mental o está preocupado sobre la salud mental de otra persona, usted puede llamar o enviar un mensaje de texto al 9-8-8.
Si usted se encuentra sin hogar y necesita asistencia inmediata, por favor marque el 2-1-1.

ACTION REQUIRED: None

If you have any questions, please reach out to the NJ TBI Fund at Dhsco.DDS-TBIFund@dhs.nj.gov or call 1-888-285-3036

Please do not respond directly to this e-mail. The originating e-mail account is not monitored.
Confidentiality Notice: This email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, destroy all copies of the original message.

An email notification is sent to the requester, notifying them that it is now under the review of their Healthcare Provider.

Traumatic Brain Injury Fund Application

Physician Review Complete

Hello Jane Doe,

This is to notify you that your TBI-APP#:00117 has been received by TBI with medical documentation completed by the Physician, and will be reviewed by the appropriate staff for follow-up. Please allow some time for response.

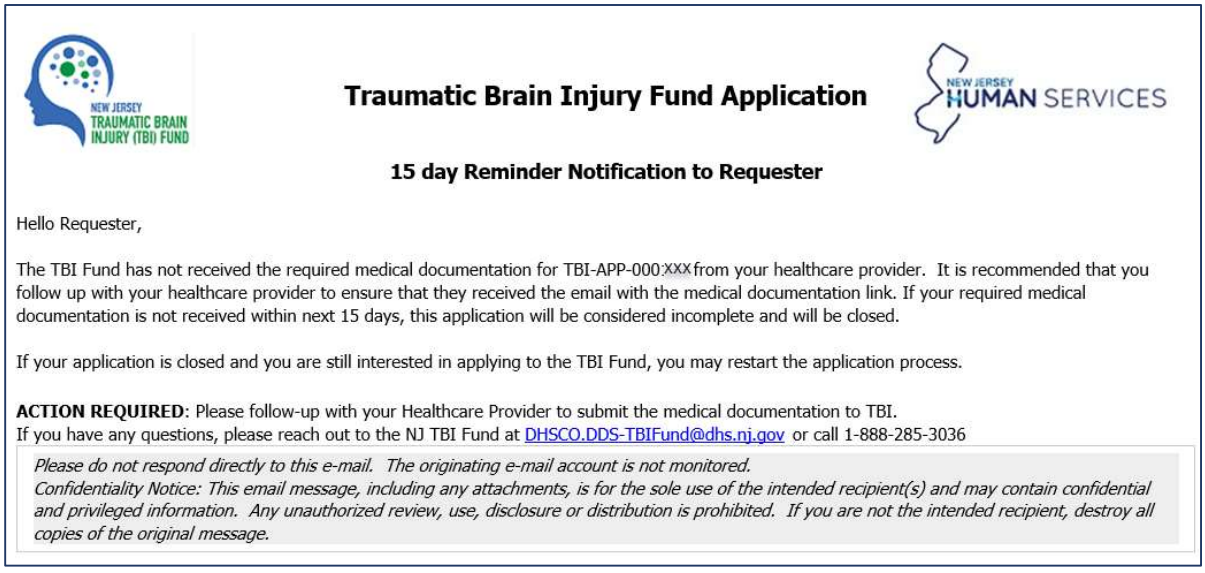
ACTION REQUIRED: None

If you have any questions, please reach out to the NJ TBI Fund at Dhsco.DDS-TBIFund@dhs.nj.gov or call 1-888-285-3036

Please do not respond directly to this e-mail. The originating e-mail account is not monitored.
Confidentiality Notice: This email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, destroy all copies of the original message.

An email notification is sent to the requester, notifying them that the healthcare provider has not received the medical documentation.

Note: Your application is cancelled after 30 days if your healthcare provider does not submit their review of the TBI Fund Application.



Traumatic Brain Injury Fund Application

15 day Reminder Notification to Requester

Hello Requester,

The TBI Fund has not received the required medical documentation for TBI-APP-000XXX from your healthcare provider. It is recommended that you follow up with your healthcare provider to ensure that they received the email with the medical documentation link. If your required medical documentation is not received within next 15 days, this application will be considered incomplete and will be closed.

If your application is closed and you are still interested in applying to the TBI Fund, you may restart the application process.

ACTION REQUIRED: Please follow-up with your Healthcare Provider to submit the medical documentation to TBI.
If you have any questions, please reach out to the NJ TBI Fund at DHSCO.DDS-TBIFund@dhs.nj.gov or call 1-888-285-3036

Please do not respond directly to this e-mail. The originating e-mail account is not monitored.
Confidentiality Notice: This email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, destroy all copies of the original message.

If the Healthcare Provider does not review your application within 30 days, an email notification is sent to the requester, notifying them that their TBI Fund Application has been cancelled.

Traumatic Brain Injury Fund Application

TBI Fund Application Cancelled

Dear Requester,

The TBI Fund has not received the required medical documentation from your healthcare provider. This application is incomplete and has been closed.

If your application is closed and you are still interested in applying to the TBI Fund, you may restart the application process.

If you have any questions, please reach out to the NJ TBI Fund at DHSCO.DDS-TBIFund@dhs.nj.gov or 1-888-285-3036

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