Traumatic Brain Injury Fund

Call 888-285-3036
for assistance.

New Jersey Department of Human Services, TBI Fund, Division of Disability Services

Traumatic Brain Injury Fund

File # _____
Fund Use Only

Application for the Traumatic Brain Injury (TBI) Fund

General Applicant Information

For assistance with this application, call: (888) 285-3036 Press 3

Application Date: _____

Applicant Name:

_____
First MI Last

Date of Birth: _____

Address:

_____

_____

_____

County:_____

Phone: _____ E-Mail: _____

Length of time Applicant a New Jersey Resident:_____

Is Applicant a Minor Child? ☐ Yes ☐ No

Is Applicant his/her own Legal Guardian? ☐ Yes ☐ No

Parent/Legal Guardian Name:_____
First MI Last

Address:

_____

_____

_____

Phone: _____ E-Mail: _____

Did you sustain a TBI during military service? ☐ Yes ☐ No

Referred by: _____

Only Original Application Will Be Accepted

Medical Information

Applicants are expected to provide the TBI Fund with verification of all medical information. If extra space is needed, please attach additional sheets.

Date of Brain Injury: _____

Nature of Injury (How was the Applicant medically injured? Example: open skull fracture): _____

_____

_____

_____

Circumstances of Injury (How did the injury happen? Example: car crash): _____

_____

_____

_____

_____

Treatments Received (Examples: cognitive therapy, neuropsychological sessions, physical therapy, etc.): ____

_____

_____

_____

_____

Current Treating Physician (Doctor who can verify the brain injury): _____

Physician's Address: _____

Physician's Phone: _____

Functional Self-Assessment

Please use the scale below to rate the applicant's ability to perform each of the tasks.

Dressing:	☐ Unable to Perform	☐ With Assistance	☐ Performs Independently
Bathing:	☐ Unable to Perform	☐ With Assistance	☐ Performs Independently
Toileting:	☐ Unable to Perform	☐ With Assistance	☐ Performs Independently
Walking:	☐ Unable to Perform	☐ With Assistance	☐ Performs Independently
Eating:	☐ Unable to Perform	☐ With Assistance	☐ Performs Independently

Review the below list of activities. Please circle the activity(s) applicant has difficulty doing as a result of his or her brain injury:

Speaking	Managing Emotions	Remembering
Managing Money	Reading	Following Written Directions
Following Spoken Directions	Writing	Finding Words
Making and Keeping Appointments	Using the Telephone	Socializing

Support Information

What is Applicant's current living situation? Please circle appropriate choice:

(A) In the Community Alone (Example: in a house or apartment alone)? _____

(B) In the Community with Others (Example: with family or other people)
How many people reside with applicant?_____

(C) In a Facility (Example: in a rehabilitation center or hospital)
What is name of the facility? _____

What is Applicant's marital status? (Circle appropriate choice)

(A) Single **(B)** Married **(C)** Divorced/Separated **(D)** Widowed

Does Applicant have any minor aged children (18 or younger)? ☐ Yes ☐ No

Is Applicant currently employed? ☐ Yes ☐ No

Does Applicant require communication accommodation (Example: speaking slowly, repetition/ reinforcement, written reminder, etc.) to communicate effectively with TBI Fund staff? ☐ Yes ☐ No

If **Yes**, what is the best method of communication?

(A) Verbal Communication Only **(B)** Verbal with Written Follow-Up

(C) Written Only **(D)** Other

If **Other**, please specify _____

Does Applicant drive? ☐ Yes ☐ No

Does Applicant have a current and valid driver's license? ☐ Yes ☐ No

Review the below list of topical eligible supports and services available through the TBI Fund. Please check the box(s) for supports and services that the Applicant is requesting. A case manager will discuss each selection in depth during the preparation of the (Plan of Service.) **Please remember that all requested services must be brain injury related.**

	YES	
Service Coordination (Ex. assistance with locating programs and services, organizing paperwork, paying bills, etc.)	☐	Explain _____
Evaluations (Ex. home accessibility, therapies, assistive technology, etc.)	☐	Explain _____
Cognitive Therapy (Ex. clinical intervention to assist with memory, organization, etc.)	☐	Explain _____
Home Modifications (Ex. ramps, bathroom accessibility modifications, etc.)	☐	Explain _____
Vehicle Modifications (Ex. installation of wheelchair lift, hand controls, etc.)	☐	Explain _____
Assistive Technology (Ex. communication devices, etc.)	☐	Explain _____
Equipment (Ex. walkers, wheelchairs, etc.)	☐	Explain _____
Employment Services (Ex. job coaching, job search, etc.)	☐	Explain _____
Rehabilitative Services (Ex. physical, occupational, speech, vision, audiology, etc.)	☐	Explain _____
Transportation Services (Ex. medical transport, bus, taxi, etc.)	☐	Explain _____

	YES	
Respite Care (Ex. relief for family caregiver, etc.)	☐	Explain _____
Medical Services (Ex. medical treatment, evaluations, etc.)	☐	Explain _____
Pharmaceuticals (Ex. medications, etc.)	☐	Explain _____
Educational Services (Ex. Supports related to an education program, tutoring, etc.)	☐	Explain _____
Counseling and Psychological Services (Ex. psychotherapy, etc.)	☐	Explain _____
Personal Assistance (Ex. companion services, home health aide, etc.)	☐	Explain _____
Addiction Treatment Services (Ex. addiction programs, peer support groups, etc.)	☐	Explain _____
Parental Support Services (Ex. for a brain injured child or the child of a brain injured parent, etc.)	☐	Explain _____
Life Skills Training (Ex. learning to balance a checkbook, ride the bus or other daily living skills, etc.)	☐	Explain _____

Financial Resource Information

Has Applicant received any compensation from a civil judgment or settlement related to their brain injury, or are any such activities planned or pending? ☐ Yes ☐ No

If **Yes**, please explain_____

Do the liquid assets of the Applicant exceed $100,000.? ☐ Yes ☐ No

Liquid assets are assets which can be converted to cash within 30 days. The home where the Applicant lives, vehicles, and personal property are not considered liquid assets. In situations where Applicants are children 18 yrs. of age or younger, liquid assets of the parent(s)/guardian(s) will be considered.

Cash On Hand (in Applicant's possession right now) $_____

Savings Account $_____

Checking Account $_____

Stocks/Bonds $_____

Other Liquid Assets $_____

I hereby attest that the information provided on this application is true to the best of my knowledge. I agree that the TBI Fund staff may contact medical professionals in order to obtain information relating to my brain injury or to verify the need for services/supports I am requesting. Such information will be used only to verify eligibility for the TBI Fund and/or to support requests from the TBI Fund.

_____ _____

Applicant/Parent/Legal Guardian Signature Date

_____

Please Print Name

_____

Relationship to Applicant

_____

Daytime Telephone Number

Please return completed application to:

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

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

Produced by DHS Office of Publications Rev. 8/16