

## TBI Application Process

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

1. Navigate to the following website:  
<http://www.nj.gov/humanservices/dds/programs/braininjuryfund/>
2. Scroll down to **Apply Now**.

Home / Program and Services / Traumatic Brain Injury Fund

### Traumatic Brain Injury Fund

The Division of Disability Services (DDS) is the designated lead state government agency for brain injury. As such, the Division administers the Traumatic Brain Injury (TBI) Fund and serves as staff to the Governor's NJ Advisory Council on Traumatic Brain Injury.

The Traumatic Brain Injury (TBI) Fund provides New Jersey residents of any age, who have survived a traumatic brain injury, the opportunity to access the brain injury related services and supports they need to live in the community.

The Fund purchases supports and services to foster independence and maximize quality of life when insurance, personal resources, and/or public programs are unavailable to meet those needs. A portion of the Fund also is used to support public education, outreach, and prevention activities related to TBI.

#### Eligibility

Fund recipients must:

- Provide medical documentation of brain injury
- Have liquid assets of less than \$100,000
- Be a resident of New Jersey for at least 90 consecutive days

[TBI Fund Brochure \(English\)](#), [\(Spanish\)](#)

#### Definitions

##### Traumatic Brain Injury

To qualify for the Fund, an individual must have sustained a traumatic brain injury; defined as an injury to the brain caused by a blow or jolt to the head or a penetrating head injury/neuro-trauma that disrupts the normal brain function, where continued impairment can be demonstrated. This definition does not include dysfunction caused by congenital or degenerative disorders, birth trauma, acquired brain injuries (stroke, aneurysm, etc.) or injuries caused by other circumstances.

##### Liquid Assets

Liquid assets include checking accounts, savings accounts, CDs, stocks and bonds. The Fund does not consider your primary home or your primary vehicle as "liquid assets," nor do we consider your IRA or 401k, unless you are of retirement age.

##### Services and Supports

The Fund will consider services and supports that are related to your brain injury. These may include but are not limited to:

- Home modifications
- Service coordination
- Assistive technology
- Cognitive therapy
- Neuropsychological services
- Pharmaceuticals
- Physical, Occupational, and Speech Therapies

#### Application for the TBI Fund

To begin the application process please click on 'Apply Now'. You will be asked a series of questions and required to upload copies of eligibility documents. You may click the 'Save' button at the bottom of the application form to save a draft of your application and complete it at a later time. After you click 'Submit' your application will be sent to your healthcare provider for the medical documentation.

Once the TBI Fund receives the completed application, your eligibility will be reviewed and a determination letter will be sent to you.

For more instructions and an example of a completed application please use the TBI Application Guide and Application Sample found below. If you need additional assistance, contact DDS at [1-888-285-3036](tel:1-888-285-3036) prompt #1.

[Apply Now](#)

[TBI Application Guide \(PDF\)](#)  
[TBI Application Sample \(PDF\)](#)  
[TBI Healthcare Provider Submission Guide \(PDF\)](#)

Once you select **Apply Now**, the following form is displayed:



**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 automatically be emailed the Medical Form to complete and sign. Once your completed application is received, it will be reviewed and you will be notified of your eligibility. You may contact the TBI Fund 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.

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**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 \***

**Upload one of the documents from a list below \***

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

**Upload your document \***

**Preferred Method of Communication**

Verbal  
  Written  
  Verbal with written follow-up

**Is someone filling this form out on your behalf?**

Yes  
 No

## Applicant Information

1. Enter the required information.

**Applicant Information**

<b>First Name *</b>	<b>Middle Initial</b>	<b>Last Name *</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Address *</b>		
<input type="text"/>		
<b>Apt/Unit/Suite/POBox Number</b>	<b>Phone *</b>	
<input type="text"/>	<input type="text"/>	
<b>Email (This email will be used for acknowledgment and notifications) *</b>	<b>Date of Birth *</b>	
<input type="text"/>	<input type="text" value="MM/DD/YYYY"/>	

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.**

Upload one of the documents from a list below \*

<input type="radio"/> Driver's License <input type="radio"/> State ID <input type="radio"/> Government Issued Correspondence <input type="radio"/> Current Utility Bill	Upload your document * <div style="background-color: #0070C0; color: white; padding: 5px; display: inline-block; border-radius: 3px;">Select files...</div>
--	--

Preferred Method of Communication

Verbal   
  Written   
  Verbal with written follow-up

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

Is the person filling this form is different from Applicant?

Yes  
 No

**Note: If you selected Yes, an additional section opens. Please follow the process starting at [section 2a](#).**

Is the person filling this form is different from Applicant?

Yes  
 No

Person filling out form, if different from Applicant: \*

-- Select one --

First Name \*                      Middle Initial                      Last Name \*

                                          

Address \*

Apt/Unit/Suite/POBox Number                      Phone \*                      Email \*

e.g Apt/unit/suite

Section 2a

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

Person filling out form, if different from Applicant: \*

-- Select one --

- Select one --
- Power of Attorney
- Legal Guardian
- Parent
- Other

Middle Initial

Last Name \*

Apt/Unit/Suite/POBox Number

Phone \*

Email \*

**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.**

Person filling out form, if different from Applicant: \*

Legal Guardian

Upload Documentation of Power of Attorney or Legal Guardian \*

Select files...

---

Person filling out form, if different from Applicant: \*

Other

Provide explanation for "Other" \*



Applicant Demographic Information

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

The screenshot shows a form titled "Applicant Demographic Information" with four required fields, each marked with a red asterisk. The fields are: "Citizenship Status", "Marital Status", "Gender Identity", and "Race/Ethnicity". Each field contains a drop-down menu with the text "-- Select one --" and a downward arrow.

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

This screenshot shows the "Citizenship Status" drop-down menu expanded. The menu lists four options: "-- Select one --", "US Citizen or US National", "Naturalized or Derived Citizen (born outside of the US)", and "Permanant Resident". The "Naturalized or Derived Citizen (born outside of the US)" option is highlighted with a red box.

**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.**

Citizenship Status *	Certificate Type *
<input type="text" value="Naturalized or Derived Citizen (bo..."/>	<input type="text" value="-- Select one --"/>
Upload US Passport (expired is ok) or Permanent Resident Card *	Certificate # *
<input type="button" value="Select files..."/>	<input type="text"/>

**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.**

Citizenship Status *	Upload US Passport (expired is ok) or Permanent Resident Card *
<input type="text" value="Permanant Resident"/>	<input type="button" value="Select files..."/>

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

Level of Education \*

-- Select one --

Do you have dependent children? (A dependent is a qualifying child who relies on you for financial support) \*

-- Select one --

Employment Status \*

-- Select one --

What is your living situation? \*

-- Select one --

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

What is your living situation? \*

Home

Own or Rent? \*

Own

Rent

## Medical Information

1. Select the **Year most recent TBI occurred (yyyy)**.

The screenshot shows the 'Medical Information' form with three fields: 'Year most recent TBI occurred (yyyy) \*', 'Date TBI occurred (mm/dd)', and 'Cause of TBI \*'. The year dropdown menu is open, displaying a list of years from 2018 to 2024. The date field contains the placeholder 'MM/DD' and the cause of TBI field is empty.

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

The screenshot shows the 'Medical Information' form with the year dropdown menu now closed and '2024' selected. The date field still contains the placeholder 'MM/DD' and the cause of TBI field is empty. A new field, 'Treatment received for TBI \*', is visible below the other fields and is currently empty.



2. Enter your **Annual Income (For applicants 18 years or younger, income of parents or guardian. For married applicants, total combined marital 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 menus.**

**Financial Information**

Annual Income (For applicants 18 years or younger, income of parents or guardian. For married applicants, total combined marital income) \$ \*

Wages (\$), If not received, enter \$0 \*

Social Security (\$), If not relevant to you, enter \$0 \*

Alimony received (\$), If not relevant to you, enter \$0 \*

Worker's Compensation/ Disability (\$), If not relevant to you, enter \$0 \*

Other income (\$), If not relevant to you, enter \$0 \*

How often?

-- Select one --

-- Select one --

Daily

Weekly

Bi-Weekly

Monthly

Quarterly

Semi-Annually

Annually

-- Select one --

How often?

-- Select one --

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

Have you received a settlement or civil judgment made in connection to your TBI? \*

Yes

No

Do not know

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

Have you received a settlement or civil judgment made in connection to your TBI? \*

Yes  
 No  
 Do not know

<p>Type of Settlement *</p> <div style="border: 1px solid gray; padding: 2px;">-- Select one --</div>	<p>Docket Number *</p> <div style="border: 1px solid gray; height: 20px;"></div>
<p>Amount of settlement \$ *</p> <div style="border: 1px solid gray; height: 20px;"></div>	<p>Attorney Name *</p> <div style="border: 1px solid gray; height: 20px;"></div>
<p>Attorney Email *</p> <div style="border: 1px solid gray; height: 20px;"></div>	<p>Attorney Phone *</p> <div style="border: 1px solid gray; height: 20px;"></div>
<p>Attorney Address *</p> <div style="border: 1px solid gray; height: 20px;"></div>	

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

Are there any pending claims such as, lawsuits, divorce settlements, inheritance, accident claims, medical malpractice, or other claims? \*

Yes  
 No  
 Do not know

**Note: If you select Yes, please provide an explanation.**

Are there any pending claims such as, lawsuits, divorce settlements, inheritance, accident claims, medical malpractice, or other claims? \*

Yes  
 No  
 Do not know

If yes, please provide details of the claims, including but not limited to, the date monies were received and the type of claim. \*

- If relevant, select **Yes** or **No** in the required or relevant questions regarding liquid assets that are \$100,000 or more. Attach the required documents.

**Note: Once you enter an amount in any of the Accounts fields, the Select files... are displayed. Please enter "0", if this is not relevant.**

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.**

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. \**

Yes  
 No

Savings Amount (\$) * <input type="text" value="100000"/>	Please upload prior bank statements (1) * <input type="button" value="Select files..."/>	Please upload prior bank statements (2) * <input type="button" value="Select files..."/>	Please upload prior bank statements (3) * <input type="button" value="Select files..."/>
Additional saving account			
<input checked="" type="radio"/> Yes <input type="radio"/> No			
Additional Saving amount (\$) * <input type="text" value="100000"/>	Please upload prior bank statements (1) * <input type="button" value="Select files..."/>	Please upload prior bank statements (2) * <input type="button" value="Select files..."/>	Please upload prior bank statements (3) * <input type="button" value="Select files..."/>
Checking Amount (\$) * <input type="text" value="100000"/>	Please upload prior bank statements (1) * <input type="button" value="Select files..."/>	Please upload prior bank statements (2) * <input type="button" value="Select files..."/>	Please upload prior bank statements (3) * <input type="button" value="Select files..."/>
Additional checking account			
<input checked="" type="radio"/> Yes <input type="radio"/> No			
Additional Checking Amount (\$) * <input type="text" value="100000"/>	Please upload prior bank statements (1) * <input type="button" value="Select files..."/>	Please upload prior bank statements (2) * <input type="button" value="Select files..."/>	Please upload prior bank statements (3) * <input type="button" value="Select files..."/>
Stock/Bonds (\$) * <input type="text" value="100000"/>	Please upload most recent Stock/Bonds Quarterly statement(s) * <input type="button" value="Select files..."/>		
Other Assets(\$) (i.e. Trust Fund) * <input type="text" value="10000"/>	Please upload most recent Other Assets Quarterly statement(s) * <input type="button" value="Select files..."/>		

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

Do you receive Direct express?  
 \*

Yes  
 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.**

Do you receive Direct express? * <input checked="" type="radio"/> Yes <input type="radio"/> No	Please upload prior bank statements (1) * <input type="button" value="Select files..."/>	Please upload prior bank statements (2) * <input type="button" value="Select files..."/>	Please upload prior bank statements (3) * <input type="button" value="Select files..."/>
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**8. Select Yes or No.**

Do you own or have interest in whole or in part, any properties other than your primary residence (including but not limited to Other homes, Land, Buildings, timeshares, and Life estates)? \*

Yes  
 No

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

Do you own or have interest in whole or in part, any properties other than your primary residence (including but not limited to Other homes, Land, Buildings, timeshares, and Life estates)? \*

Yes  
 No

Type(s) of Property * <input style="width: 90%;" type="text"/>	Address of Property <input style="width: 90%;" type="text"/>
Type(s) of Property <input style="width: 90%;" type="text"/>	Address of Property <input style="width: 90%;" type="text"/>
Type(s) of Property <input style="width: 90%;" type="text"/>	Address of Property <input style="width: 90%;" type="text"/>

Health Insurance Information

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

**Health Insurance Information**

---

**Do you have health insurance? \***

Yes

No

**Note: By selecting Yes, you have to select a Type of Insurance. 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.**

**Health Insurance Information**

---

**Do you have health insurance? \***

Yes

No

**Type of insurance \***

Private    Medicaid Managed Care Organization (MCO)    Medicare    Dental    Vision    Other

**Private Policy Name \***

**Private Policy Number \***

**Medicare Part A Date Eligible \***

**Medicare Part B Date Eligible**

**Medicare Part C Date Eligible**

**Medicare Part D Date Eligible**

**Medicaid Managed Care Organization (MCO) Name**

**Medicaid Managed Care Organization (MCO) Policy Number \***

**Dental Policy Name \***

**Dental Policy Number \***

**Vision Policy Name \***

**Vision Policy Number \***

**Other, please explain \***

## Services Information

1. Select the programs that you are enrolled in.

**Services Information**

---

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

<input type="checkbox"/> Personal Assistance Service Program (PASP)	<input type="checkbox"/> Division of Developmental Disabilities (DDD) Waiver	<input type="checkbox"/> Jersey Assistance for Community (JACC)	<input type="checkbox"/> Managed Long Term Services and Supports (MLTSS)
<input type="checkbox"/> Veteran Affairs	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Pharmaceutical Assistance to the Aged & Disabled (PAAD)/Senior Gold	<input type="checkbox"/> Other Services
<input type="checkbox"/> 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 Services, 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**.

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).

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 Fund.

**Name \***  **Date \***

**Signature**

Signer's Name

6. Enter the required information.

(Your) Healthcare Provider Details

**Healthcare Provider Name \***  **Healthcare Provider Phone \***

Healthcare Provider's Phone Number must be different than your personal Phone Number

**Healthcare Provider Email \***  **Confirm Healthcare Provider Email \***

Healthcare Provider's emails must be different than your personal email.

**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.**

**Confirm Healthcare Provider Email \***

Healthcare Provider's emails must match

- 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.

For Office Use Only:

Was this information entered in manually by a DDS employee on behalf of the applicant?

Yes  
 No

Note: All attachments combined size should be less than 30MB.  
If you are facing any issues submitting this application online, please contact the NJ TBI Fund at [DHSCO.DDS-TBIFund@dhs.nj.gov](mailto:DHSCO.DDS-TBIFund@dhs.nj.gov) or call 1-888-285-3036.

**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.**

For Office Use Only:

Was this information entered in manually by a DDS employee on behalf of the applicant?

Yes  
 No

If yes, please upload a scanned copy of original filled and signed form received from an Originator. (Must include, signed "HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508") \*

✓ Done

 TEST - For attachments in forms.pdf ×  
File(s) uploaded successfully.

Note: All attachments combined size should be less than 30MB.  
If you are facing any issues submitting this application online, please contact the NJ TBI Fund at [DHSCO.DDS-TBIFund@dhs.nj.gov](mailto:DHSCO.DDS-TBIFund@dhs.nj.gov) or call 1-888-285-3036.

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](mailto: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](mailto: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-000:XXX 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](mailto:DHSCO.DDS-TBIFund@dhs.nj.gov) or call 1-888-285-3036

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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](mailto:DHSCO.DDS-TBIFund@dhs.nj.gov) or 1-888-285-3036

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