

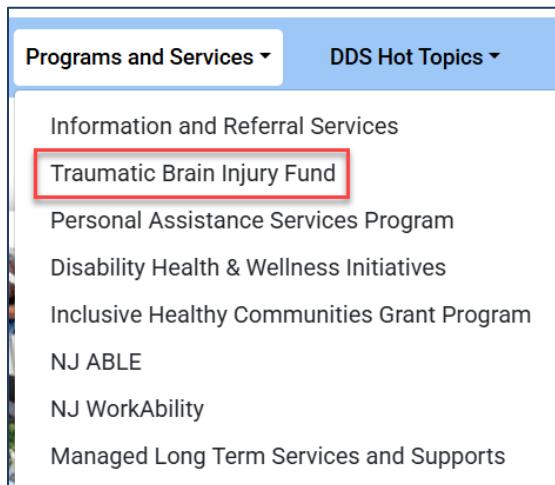
A vendor who wants to offer services to the **Traumatic Brain Injury Fund (TBI)** can find instructions on how to complete the form in this guide.

1. Navigate to the Division of Disability Services Homepage: [Division of Disability Services | Home](#)
2. Select the **Program and Services** drop-down menu.



The screenshot shows the "Division of Disability Services" homepage. The navigation menu at the top includes "Home" (with a house icon), "About Us", "Programs and Services" (which is highlighted with a red box), and "DDS Hot Topics".

3. Select **Traumatic Brain Injury Fund**.



The screenshot shows the "Programs and Services" dropdown menu. The options listed are "Information and Referral Services", "Traumatic Brain Injury Fund" (which is highlighted with a red box), "Personal Assistance Services Program", "Disability Health & Wellness Initiatives", "Inclusive Healthy Communities Grant Program", "NJ ABLE", "NJ WorkAbility", and "Managed Long Term Services and Supports".

4. Select **For Providers** on the Traumatic Brain Injury Fund page. Alternatively, scroll down to **Highlighted Resources** and navigate to **For Providers** and select **LEARN MORE**.

**Traumatic Brain Injury Fund**

DDS Home  TBIF Home  For Applicants For Providers Resources Meetings



**Traumatic Brain Injury Fund**

The Division of Disability Services (DDS) administers the Traumatic Brain Injury (TBI) Fund. The 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. It 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. A TBI is 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.

**Highlighted Resources**



For Applicants

[LEARN MORE >](#)



For Providers

[LEARN MORE >](#)



Resources

[LEARN MORE >](#)



Meetings

[LEARN MORE >](#)

 [Back to top](#)

5. Select **Learn More**.

### For Providers



**How to become a TBI Fund service provider**

Click here to access the provider application form and to learn more about the requirements and documentation needed to become a TBI Fund service provider.

**Learn More**

6. Select **Vendor Application**.

### How to become a TBI Fund service provider

If you would like to become a provider for the TBI Fund, please click on the "Vendor Application," fill out the required information and upload the necessary documentation.

**Vendor Application**

Before you apply, please make sure you complete the following steps.

1. Register your business on [NJ START](#) (the State eProcurement system).
  1. This registration must contain the proper legal name of the organization doing business with the State of New Jersey and any trade name certificates updated to the system.
  2. For questions regarding this registration process, you may contact a New Jersey state vendor administrator at [\(609\) 341-3500](tel:(609)341-3500) or [njstart@treas.nj.gov](mailto:njstart@treas.nj.gov).
  3. Please keep your contact information up to date in NJ Start.
2. In the application, please provide a summary of detailed services with the corresponding CPT codes, along with the total cost of each session (*30 mins or 60 mins only, do not use 15min increments*) or each item.
3. Provide a copy of all clinical licenses or certifications in pdf format.
4. Provide proof of insurance in pdf format.
5. Provide copies of either a Curriculum Vitae or resume for everyone who will be performing the service in pdf format.
6. If you use a third party service to handle your billing, please submit a contact who performs this function on your behalf in the designated area on the application form.

**Related Links**

 [Quick Start Guide- TBI Vendor Application Form](#)

## TBI Fund Vendor Application Form Quick Start Guide

The following form is displayed:



**TBI FUND VENDOR APPLICATION FORM**



**INSTRUCTIONS:** Complete the onboarding form below and sign it to be considered for providing services to the Traumatic Brain Injury Fund. All required fields must be completed before the form can be submitted. Once your completed form is received, it will be reviewed and you will be notified if you have been authorized to provide services. You may contact the TBI Fund at 1-888-285-3036, prompt #1 for questions or assistance completing the form.

Items in \* are required fields.

### Vendor Information

Vendor Legal Name *	DBA (if applicable)	NJ START # *
<input type="text"/>	<input type="text"/>	<input type="text"/>
Vendor Address *	Unit/Suite/POBox Number	
<input type="text"/>	<input type="text"/>	
Primary Contact Name *	Email *	Phone Number *
<input type="text"/>	<input type="text"/>	<input type="text"/>

Check here if using a third-party billing service:

<b>Upload Resume(s) *</b> <input type="button" value="Select files..."/>	<b>Upload Insurance *</b> <input type="button" value="Select files..."/>
---	---

**Participating insurance companies (check all that apply) \***

<input type="checkbox"/> --Select all-- <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/N Family Care <input type="checkbox"/> Aetna <input type="checkbox"/> Ambetter from WellCare of New Jersey	<input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Healthcare
<input type="checkbox"/> AmeriHealth HMO Inc. and AmeriHealth Ins. Co.	<input type="checkbox"/> Horizon Blue Cross Blue Shield of NJ
<input type="checkbox"/> Cigna Behavioral Health Plan	<input type="checkbox"/> Humana
<input type="checkbox"/> Oxford Health Insurance (NJ) Inc.	<input type="checkbox"/> United Healthcare Insurance Company
<input type="checkbox"/> Veteran's Administration Community Care Network (VACCN)	<input type="checkbox"/> Veterans Choice Program
	<input type="checkbox"/> Oscar

### Service Information

Number of proposed services provided by vendor \*

<input type="button" value="-- Select one --"/>	
---	--

You may upload document(s) to support your request

<input type="button" value="Select files..."/>	
--	--

I certify that the information provided in this vendor application is true and correct to the best of my knowledge, and that I agree to comply with the terms and conditions as per NJAC 10:141. I understand that I must disclose the status of all other sources for which payment was requested, denied or received for any claim submitted to the NJ TBI Fund. Such sources include but are not limited to Medicaid, Medicare, Worker's Compensation or any other private or public insurance or payer.\*

<b>Name *</b> <input type="text"/>	<b>Date *</b> <input type="text" value="12/05/2025"/>
---------------------------------------	--

**Vendor Signature \***

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## TBI Fund Vendor Application Form Quick Start Guide

7. Enter the required information.

**Vendor Information**

<b>Vendor Legal Name *</b>	<b>DBA (if applicable)</b>	<b>NJ START # *</b>
<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>
<b>Vendor Address *</b>	<b>Unit/Suite/POBox Number</b>	
<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>	

8. Enter the required information.

9. If relevant, select the **Check here if using a third-party billing service:** box.

<b>Primary Contact Name *</b>	<b>Email *</b>	<b>Phone Number *</b>
<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>

**Check here if using a third-party billing service:**

**Note: If the check box is selected, an additional section is displayed. Please enter the required information.**

**Check here if using a third-party billing service:**

<b>Name of Billing Service *</b>	<b>Billing Contact Name *</b>
<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>
<b>Billing Email *</b>	<b>Billing Phone Number *</b>
<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>

10. Upload the required files.

<b>Upload Resume(s) *</b>	<b>Upload Insurance *</b>
<b>Select files...</b>	<b>Select files...</b>

11. Select the **Participating insurance companies** (check all that apply).

**Participating insurance companies (check all that apply) \***

Medicare    Medicaid/NJ Family Care    Aetna    Ambetter from WellCare of New Jersey  
 AmeriHealth HMO Inc. and AmeriHealth Ins. Co.    Blue Cross Blue Shield    Cigna Healthcare  
 Cigna Behavioral Health    Clover Health Plan    Humana    Horizon Blue Cross Blue Shield of NJ    Oscar  
 Oxford Health Insurance (NJ) Inc.    United Healthcare Insurance Company  
 Veteran's Administration Community Care Network (VACCN)    Veterans Choice Program    Other

**Note: An additional field is displayed if Other is selected. Please include the necessary details.**

Veteran's Administration Community Care Network (VACCN)    Veterans Choice Program    Other

**Please add Participating insurance company name if selected (Other) \***

12. If relevant, select the **Number of proposed services provided by the vendor** drop-down menu.

**Service Information**

**Number of proposed services provided by vendor**

-- Select one --

1  
 2  
 3  
 4  
 5

ed in this vendor's conditions as requested, to Medicaid, I

**Note: The additional sections displayed are determined by the vendor's selection of the number of proposed services.**

**Service Information**

Number of proposed services provided by vendor \*

2

**Service 1**

Service Name-1 *	CPT Code *
<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Check here if you have a license or certification required to practice or provide the(se) service(s).	
Service Description * <div style="border: 1px solid #ccc; height: 100px; margin-top: 5px;"></div>	

**Note:** The TBI Fund is not an insurance provider and does not use insurance billing increments. Rates should be for the entire session and not broken down by billing increments.

Rate (Total amount per session or item) *	Unit (i.e., per item, 30 or 60 min session) *
\$   \$	<input type="text"/>

**Service 2**

Service Name-2 *	CPT Code *
<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Check here if you have a license or certification required to practice or provide the(se) service(s).	
Service Description * <div style="border: 1px solid #ccc; height: 100px; margin-top: 5px;"></div>	

**Note:** The TBI Fund is not an insurance provider and does not use insurance billing increments. Rates should be for the entire session and not broken down by billing increments.

Rate (Total amount per session or item) *	Unit (i.e., per item, 30 or 60 min session) *
\$   \$	<input type="text"/>

## TBI Fund Vendor Application Form Quick Start Guide

13. Enter the relevant and required information.
14. If relevant, select **Check here if you have a license or certification required to practice or provide the(se) service(s).**

Service Name-1	CPT Code *
<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Check here if you have a license or certification required to practice or provide the(se) service(s).	

**Note: If the check box is selected, please enter the required and relevant information.**

<input checked="" type="checkbox"/> Check here if you have a license or certification required to practice or provide the(se) service(s).				
Licensing Body *	Credential # *	Active Date (From)	Active Date (To)	Upload License(s)/Certificate(s) (If Applicable) *
<input type="text"/>	<input type="text"/>	<input type="text"/> MM/dd/yyyy	<input type="text"/> MM/dd/yyyy	<input type="button" value="Select files..."/>

15. Enter the required information.

<p>Service Description *</p> <input type="text"/> <p><small>Note: The TBI Fund is not an insurance provider and does not use insurance billing increments. Rates should be for the entire session and not broken down by billing increments.</small></p> <p>Rate (Total amount per session or item) *</p> <input type="text"/> \$	<p>Unit (i.e., per item, 30 or 60 min session) *</p> <input type="text"/>
---	---

## TBI Fund Vendor Application Form Quick Start Guide

16. If relevant, **upload document(s) to support your request.**

17. Select the **I certify** check box.

You may upload document(s) to support your request

[Select files...](#)

I certify that the information provided in this vendor application is true and correct to the best of my knowledge, and that I agree to comply with the terms and conditions as per N.J.A.C 10:141. I understand that I must disclose the status of all other sources for which payment was requested, denied or received for any claim submitted to the NJ TBI Fund. Such sources include but are not limited to Medicaid, Medicare, Worker's Compensation or any other private or public insurance or payer.\*

18. Enter the vendor **Name**.

19. **Type, Draw, or Upload the Vendor Signature.**

**Note: The Date is automatic and cannot be changed. If you wish to clear the form and start over, select Clear. This will delete the information that you entered.**

20. Select **Submit**.

Name \*

Date \*

Vendor Signature \*

Signer's Name

Type

Draw

Upload

Clear

2025.12.V1.2

Clear

Submit

The following message is displayed once the form has been submitted.



NEW JERSEY  
TRAUMATIC BRAIN  
INJURY (TBI) FUND

**TBI FUND VENDOR APPLICATION FORM**



NEW JERSEY HUMAN SERVICES  
Division of  
Disability  
Services

Thank you for contacting the NJ Department of Human Services.  
Your submission (TRAUMATIC BRAIN INJURY FUND: VENDOR APPLICATION) has been received and will be reviewed by the appropriate staff.

### Email Notifications

Once the vendor submits the application, they are notified via email of the status and outcome. Every individual service requested on the application has an individual outcome. The possible outcomes that a vendor may receive are a request for additional information, approved/partially approved, canceled, or rejected.

### Submission Confirmation Email Notification

The vendor receives a confirmation email once the form has been submitted.



**Traumatic Brain Injury Vendor Application**



**Submission Confirmation**

Dear Jane Doe,

Thank you for contacting the NJ Department of Human Services, TBI, NJ Traumatic Brain Injury Fund (TBI Fund).

Your submission has been received and will be reviewed by the appropriate staff.

**ACTION REQUIRED:** None.

If you have any questions, please contact the NJ TBI Fund at [DDS-TBI.VendorApplications@dhs.nj.gov](mailto:DDS-TBI.VendorApplications@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.*

### Request for Additional Information

The vendor receives the following email notification if additional information is needed. The procedure below explains how to review and add the information required. For examples of where to find the information that is requested on the form, see **Request for Additional Information by the TBI Analyst** or **Request for Additional Information by the TBI Supervisor**.

**Note: The TBI Analyst or TBI Supervisor may request additional information. See the examples below.**

#### Request for Additional Information by the TBI Analyst

1. Navigate to the TBIF-VAPP email.
2. Select **Review Online**.

 <b>Traumatic Brain Injury Vendor Application</b> <b>Request for Additional information</b>  Dear Jane Doe,  We received a vendor application to the NJ Traumatic Brain Injury (TBI). After review, additional information is needed to proceed with the application re-review process. You have until <b>01/03/2026</b> to provide the requested information. If you do not submit the required documentation within the due date mentioned above, your application will be considered incomplete and closed.  <b>ACTION REQUIRED:</b> <a href="#">Review online</a> to provide additional information. Click Submit once done.  Please find Vendor's information below:  <b>Vendor Legal Name:</b> Jane Doe  <b>NJ START #:</b> 45345 <b>Vendor Address:</b> 350, Engle Street, Englewood, New Jersey, Bergen County, 07631  <b>Primary Contact Name:</b> Jane Doe <b>Email:</b> <a href="mailto:roni.cohen@dhs.nj.gov">roni.cohen@dhs.nj.gov</a> <b>Phone Number:</b> (123) 456-7879  If you have any questions, please contact the NJ TBI Fund at <a href="mailto:DDS-TBI.VendorApplications@dhs.nj.gov">DDS-TBI.VendorApplications@dhs.nj.gov</a> or call 1-888-285-3036.  <small><i>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.</i></small>	 NEW JERSEY HUMAN SERVICES <b>DDS</b> DIVISION OF DISABILITY SERVICES
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## TBI Fund Vendor Application Form Quick Start Guide

3. Once the form is displayed, scroll down to the **Services** section.
4. Search for the **Service** that says "**Action Required: Please review comments by TBI Fund Staff**," highlighted in red.
5. Review the comment and make the relevant edits/ changes.

**Service Information**

Number of proposed services provided by vendor  
2

**Service 1**

Service Name-1 Test 1	CPT Code * 97110
--------------------------	---------------------

Check here if you have a license or certification required to practice or provide the(se) service(s).

**Service Description \***  
Therapeutic Exercise

Note: The TBI Fund is not an insurance provider and does not use insurance billing increments. Rates should be for the entire session and not broken down by billing increments.

Rate (Total amount per session or item) * \$ 100.00	Unit (i.e., per item, 30 or 60 min session) * 30
--	---

TBI Analyst Decision for Service-1:  
Reviewed

**Service 2**

Service Name-2 Test 2	CPT Code * 97140
--------------------------	---------------------

Check here if you have a license or certification required to practice or provide the(se) service(s).

**Service Description \***  
Therapy

Note: The TBI Fund is not an insurance provider and does not use insurance billing increments. Rates should be for the entire session and not broken down by billing increments.

Rate (Total amount per session or item) * \$ 90.00	Unit (i.e., per item, 30 or 60 min session) * 60
---	---

**Action Required: Please review comments by TBI Fund Staff**

TBI Analyst Decision for Service-2:  
Require Additional Information

Comments from TBI Analyst for Service-2:  
Please add more details.

**Request for Additional Information by the TBI Supervisor**

1. Navigate to the TBIF-VAPP email.
2. Select **Review Online**.

**Traumatic Brain Injury Vendor Application**  


**Request for Additional information**

Dear Jane Doe,

We received a vendor application to the NJ Traumatic Brain Injury (TBI). After review, additional information is needed to proceed with the application re-review process. You have until **01/03/2026** to provide the requested information. If you do not submit the required documentation within the due date mentioned above, your application will be considered incomplete and closed.

**ACTION REQUIRED:** [Review online](#) to provide additional information. Click Submit once done.

Please find Vendor's information below:

**Vendor Legal Name:** Jane Doe

**NJ START #:** 45345  
**Vendor Address:** 350, Engle Street, Englewood, New Jersey, Bergen County, 07631

**Primary Contact Name:** Jane Doe  
**Email:** [roni.cohen@dhs.nj.gov](mailto:roni.cohen@dhs.nj.gov)  
**Phone Number:** (123) 456-7879

If you have any questions, please contact the NJ TBI Fund at [DDS-TBI.VendorApplications@dhs.nj.gov](mailto:DDS-TBI.VendorApplications@dhs.nj.gov) or call 1-888-285-3036.

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## TBI Fund Vendor Application Form Quick Start Guide

3. Once the form is displayed, scroll down to the **Services** section.
4. Search for the **Service** that says “**Action Required: Please review comments by TBI Fund Staff**,” highlighted in red.
5. Review the comment and make the relevant edits/ changes.

**Service Information**

Number of proposed services provided by vendor  
2

**Service 1**

Service Name-1 <input type="text" value="Test 1"/>	CPT Code * <input type="text" value="97110"/>
<input type="checkbox"/> Check here if you have a license or certification required to practice or provide the(se) service(s).	
<b>Service Description *</b> <input type="text" value="Therapeutic Exercise"/>	

Note: The TBI Fund is not an insurance provider and does not use insurance billing increments. Rates should be for the entire session and not broken down by billing increments.

Rate (Total amount per session or item) * <input type="text" value="\$ 100.00"/>	Unit (i.e., per item, 30 or 60 min session) * <input type="text" value="30"/>
---	--

**Action Required: Please review comments by TBI Fund Staff**

TBI Analyst Decision for Service-1  
Reviewed

TBI Supervisor Decision for Service-1  
Require Additional Information

Comments from TBI Supervisor for Service-1  
Require Following Additional Information:

**Service 2**

Service Name-2 <input type="text" value="Test 2"/>	CPT Code * <input type="text" value="97140"/>
<input type="checkbox"/> Check here if you have a license or certification required to practice or provide the(se) service(s).	
<b>Service Description *</b> <input type="text" value="Therapy"/>	

Note: The TBI Fund is not an insurance provider and does not use insurance billing increments. Rates should be for the entire session and not broken down by billing increments.

Rate (Total amount per session or item) * <input type="text" value="\$ 90.00"/>	Unit (i.e., per item, 30 or 60 min session) * <input type="text" value="60"/>
--	--

TBI Analyst Decision for Service-2  
Reviewed

TBI Supervisor Decision for Service-2  
Approved

Comments from TBI Supervisor for Service-2  
Approved

The vendor receives a confirmation email once the form has been resubmitted.



**Traumatic Brain Injury Vendor Application**



**Submission Confirmation**

Dear Jane Doe,

Thank you for contacting the NJ Department of Human Services, TBI, NJ Traumatic Brain Injury Fund (TBI Fund).

Your submission has been received and will be reviewed by the appropriate staff.

**ACTION REQUIRED:** None.

If you have any questions, please contact the NJ TBI Fund at [DDS-TBI.VendorApplications@dhs.nj.gov](mailto:DDS-TBI.VendorApplications@dhs.nj.gov) or call 1-888-285-3036.

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### Canceled Email Notification

The vendor receives the following email if the requested information has not been updated and submitted after **45 days**.



NEW JERSEY  
TRAUMATIC BRAIN  
INJURY (TBI) FUND

**Traumatic Brain Injury Vendor Application**

**TBI Vendor Application Canceled**

NEW JERSEY HUMAN SERVICES



**DDS**  
DIVISION OF  
DISABILITY  
SERVICES

Dear Jane Doe,

The TBI Fund has not received the requested additional information. This application is incomplete and has been closed.

If your application is closed and you are still interested becoming a TBI Fund vendor, you will have to start the application process over.

If you have any questions, please reach out to the NJ TBI Fund at [DDS-TBI.Applications@dhs.nj.gov](mailto:DDS-TBI.Applications@dhs.nj.gov) or 1-888-285-3036

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### Application Approved/Partially Approved

The vendor receives this email notification if a service has been approved or partially approved. Applying for more than one service may mean that some services are approved, while others are not. More information is provided in the attached PDF.

 TBI VAPP Application-Complete.pdf ▼  
112 KB

 **Traumatic Brain Injury Vendor Application**

**TBI Vendor Application Approved/Partially Approved**

Hello Jane Doe,

Please review the attached PDF for details of your application TBIF-VAPP-000231 status and onboarding determination.

**ACTION REQUIRED:** None

If you have any questions, please contact the NJ TBI Fund at [DDS-TBI.VendorApplications@dhs.nj.gov](mailto:DDS-TBI.VendorApplications@dhs.nj.gov) or call 1-888-285-3036.

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### Rejected Email Notification

The vendor receives the following email if the submitted application has been rejected.

 TBI VAPP Application-Reserved.pdf ▼  
109 KB

 **Traumatic Brain Injury Vendor Application**

**TBI Vendor Application Rejected**

Hello Jane Doe,

Please review the attached PDF for details of your application TBIF-VAPP-000226 status and onboarding determination.

**ACTION REQUIRED:** None

If you have any questions, please contact the NJ TBI Fund at [DDS-TBI.VendorApplications@dhs.nj.gov](mailto:DDS-TBI.VendorApplications@dhs.nj.gov) or call 1-888-285-3036.

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