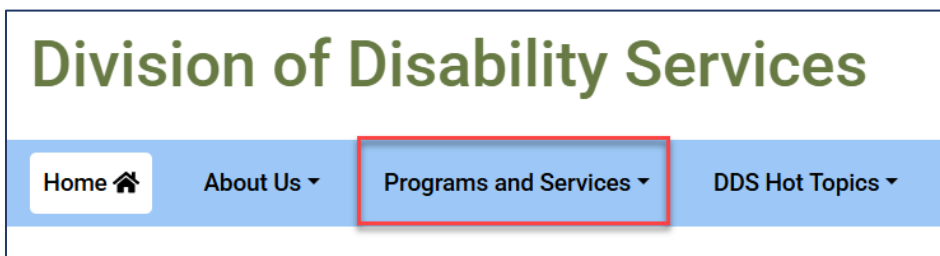


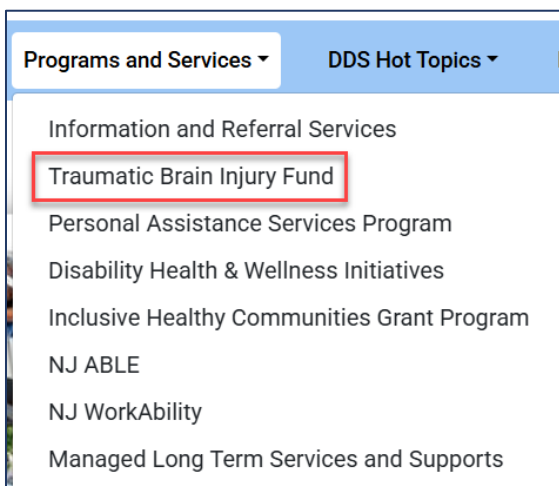
TBI Application Process

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

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



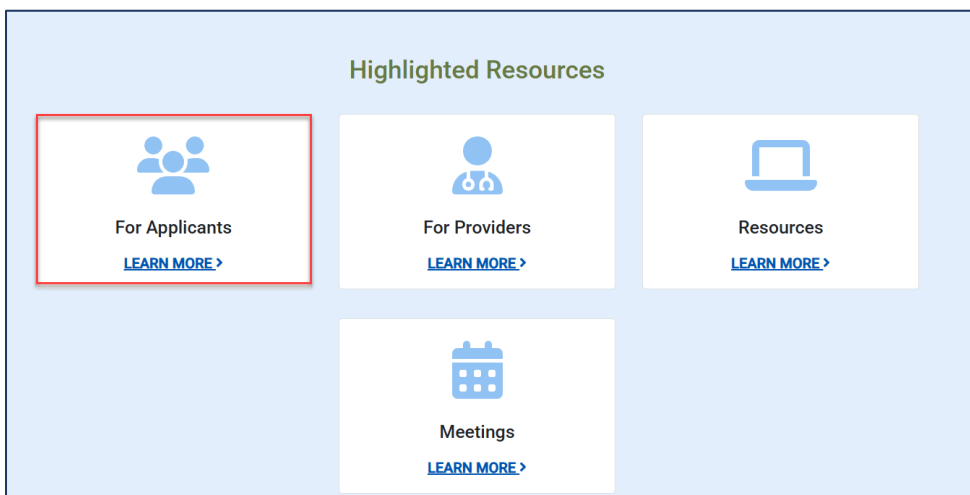
3. Select **Traumatic Brain Injury Fund**.



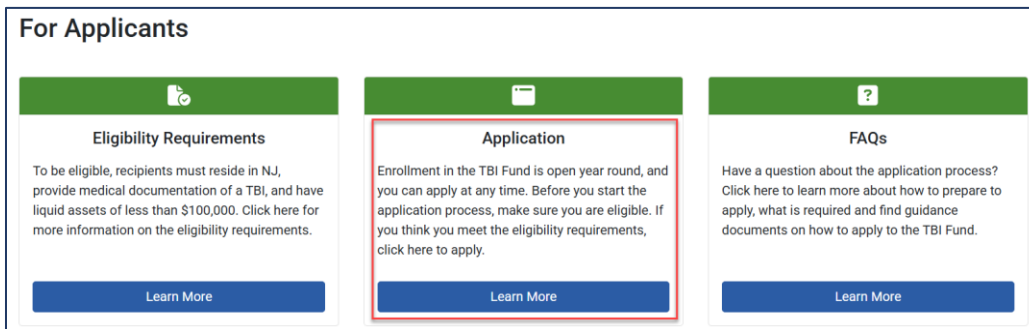
The **Traumatic Brain Injury Fund** homepage is displayed:



4. Scroll down to **Highlighted Resources**.
5. Select **LEARN MORE** under **For Applicants**.



6. Select **Learn More** under **Application**.



7. Select **Apply Now**.

Note: For further assistance, please refer to the resources found under Related Links.

Application

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. 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.

Before you start the application process, please make sure you have the following documents ready to be uploaded:

1. Three (3) most recent months of bank statements.
2. A copy of driver's license, state ID, government issued correspondence or current utility bill.
3. Your doctor's email.

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


Apply Now

Related Links

- [TBI Application Guide](#)
- [TBI Application Sample](#)
- [TBI Healthcare Provider Submission Guide](#)
- [HIPAA waiver](#)

The following form is displayed:

Note: Due to the length of the form, the first section is displayed.



TRAUMATIC BRAIN INJURY FUND APPLICATION

NEW JERSEY HUMAN SERVICES
DDS
DIVISION OF DISABILITY SERVICES

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.

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 *

Select files...

Preferred Method of Communication

☐ --Select all--
☐ 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

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

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 *

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

Upload your document *

Select files...

Preferred Method of Communication

☐ --Select all--
 ☐ Verbal
 ☐ Written
 ☐ Verbal with written follow-up

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

Is someone filling this form out on your behalf?

☐ Yes

☐ No

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

Is someone filling this form out on your behalf?

☒ Yes

☐ No

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

-- Select one --

First Name *	Middle Initial	Last Name *
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address *

Apt/Unit/Suite/POBox Number	Phone *	Email *
<input type="text" value="e.g Apt/unit/suite"/>	<input type="text"/>	<input type="text"/>

Section 2a

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

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

-- Select one --

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

Middle Initial

Last Name *

Apt/Unit/Suite/POBox Number
e.g Apt/unit/suite

Phone *

Email *

2b Enter the required and relevant information.

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

Power of Attorney

Upload Documentation of Power of Attorney or Legal Guardian *

Select files...

First Name *

Middle Initial

Last Name *

Address *

Apt/Unit/Suite/POBox Number
e.g Apt/unit/suite

Phone *

Email *

Examples of Options from the Applicant Drop-Down Menu.

Note: If you selected Yes to Person filling out the form, is different from the Applicant you may have to attach additional documents or provide an explanation.

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

Legal Guardian

Upload Documentation of Power of Attorney or Legal Guardian *

Select files...

✓ Done

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

First Name * Middle Initial Last Name *

Mary Smith

Address *

Trenton, New Jersey, Mercer County

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

e.g Apt/unit/suite (201) 464-7279 roni.cohen@dhs.nj.gov

Note: If you selected Parent, there are no additional fields.

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

Parent

First Name * Middle Initial Last Name *

Mary Smith

Address *

Trenton, New Jersey, Mercer County

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

e.g Apt/unit/suite (201) 464-7279 roni.cohen@dhs.nj.gov

Note: If you select Other, an additional field is displayed.

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

Other

Provide explanation for "Other" *

First Name * Middle Initial Last Name *

Mary Smith

Address *

Trenton, New Jersey, Mercer County

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

e.g Apt/unit/suite (201) 464-7279 roni.cohen@dhs.nj.gov

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.

Applicant Demographic Information

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

Applicant Demographic Information

Citizenship Status *

-- Select one --

Marital Status *

-- Select one --

Gender Identity *

-- Select one --

Race/Ethnicity *

-- Select one --

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

Applicant Demographic Information

Citizenship Status *

-- Select one --

-- Select one --

US Citizen or US National

Naturalized or Derived Citizen (born outside of the US)

Permanant 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.

Citizenship Status *

Naturalized or Derived Citizen (bo...

Certificate Type *

-- Select one --

Upload US Passport (expired is ok) or Permanent Resident Card *

Select files...

Certificate # *

Note: 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 * <div> <div>Permanent Resident</div> <div>▼</div> </div>	Upload US Passport (expired is ok) or Permanent Resident Card * <div>Select files...</div>
----------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------

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

Level of Education * <div>-- Select one --</div>
Do you have dependent children? (A dependent is a qualifying child who relies on you for financial support) * <div>-- Select one --</div>
Employment Status * <div>-- Select one --</div>
What is your living situation? * <div>-- Select one --</div>

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

What is your living situation? * <div>Home</div> <div>▼</div>	Own or Rent? * <div> <input type="radio"/> Own <input type="radio"/> Rent </div>
-------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------

Medical Information

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

Medical Information

Year most recent TBI occurred (yyyy) *

-- Select one --

-- Select one --

2026

2025

2024

2023

2022

2021

2020

Date TBI occurred (mm/dd)

MM/DD

Cause of TBI *

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

Year most recent TBI occurred (yyyy) *

2025

Date TBI occurred (mm/dd)

MM/DD

Cause of TBI *

Treatment received for TBI *

Financial Information

1. Enter your **Annual Income**.

Financial Information

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

\$

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

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

\$ 0.00

You have indicated \$0 income. How do 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.

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

\$ 613.00

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 *

\$

How often?

-- Select one --

-- Select one --

Daily

Weekly

Bi-Weekly

Monthly

Quarterly

Semi-Annually

Annually

-- 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> <p>-- Select one --</p>	<p>Docket Number *</p> <p></p>
<p>Amount of settlement \$ *</p> <p>\$</p>	<p>Attorney Name *</p> <p></p>
<p>Attorney Email *</p> <p></p>	<p>Attorney Phone *</p> <p></p>
<p>Attorney Address *</p> <p></p>	

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, you have to 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. *

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

7. Enter the required information.

Savings Amount (\$) *

\$

Additional saving account

☐ Yes
☐ No

Checking Amount (\$) *

\$

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.

Savings Amount (\$) * <input type="text" value="\$ 10,000.00"/>	Upload entire bank statement (Month 1) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 2) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 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="\$ 100.00"/>	Upload entire bank statement (Month 1) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 2) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 3) * <input type="button" value="Select files..."/>
Additional checking account <input checked="" type="radio"/> Yes <input type="radio"/> No			
Checking Amount (\$) * <input type="text" value="\$ 100.00"/>	Upload entire bank statement (Month 1) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 2) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 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="\$ 1,000.00"/>	Upload entire bank statement (Month 1) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 2) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 3) * <input type="button" value="Select files..."/>
Stocks/Bonds (\$) <input type="text" value="\$ 10,000.00"/>	Upload most recent Stock/Bonds Quarterly statement(s) * <input type="button" value="Select files..."/>		
Other Assets(\$)(i.e. Trust Fund) <input type="text" value="\$ 10,000.00"/>	Upload most recent Other Assets Quarterly statement(s) * <input type="button" value="Select files..."/>		
Do you receive Direct Express? * <input checked="" type="radio"/> Yes <input type="radio"/> No	Upload entire bank statement (Month 1) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 2) * <input type="button" value="Select files..."/>	Upload entire bank statement (Month 3) * <input type="button" value="Select files..."/>

8. 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.

<p>Do you receive Direct Express? *</p> <p><input checked="" type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Please upload entire bank statement (1) *</p> <p>Select files...</p>	<p>Please upload entire bank statement (2) *</p> <p>Select files...</p>	<p>Please upload entire bank statement (3) *</p> <p>Select files...</p>
---------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------	-------------------------------------------------------------------------	-------------------------------------------------------------------------

9. 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, and buildings)? *

☐ 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, and buildings)? *

☒ Yes

☐ No

Type(s) of Property *	Address of Property
<input type="text"/>	<input type="text"/>
Type(s) of Property	Address of Property
<input type="text"/>	<input type="text"/>
Type(s) of Property	Address of Property
<input type="text"/>	<input 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-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.

Health Insurance Information

Do you have health insurance? *

☒ Yes
☐ No

Type of insurance *

☒ --Select all--
☒ 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 any public programs you are enrolled in.

Services Information

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

<input type="checkbox"/> --Select all--	<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.

★

☐ --Select all--

☐ 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

☐ --Select all--

☐ 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

X

Type Draw Upload Clear

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 (Please do not enter your personal email) *

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

Confirm Healthcare Provider Email *

Note: If your email does not match in the Confirm Your Physician Email field, the message “Emails must match” is displayed. You have to confirm your email in order to submit the form.

Confirm Healthcare Provider Email *

jane.doe@gmail.com

Healthcare Provider's emails must match

7. Review the **Note**.
8. Select **Yes**, or **No** and select **Submit** once you are ready to complete the form.

Note: Individual file attachment size should be less than 100MB.
If you are facing any issues submitting this application online, please contact the NJ TBI Fund at DDS-TBI.Applications@dhs.nj.gov or call 1-888-285-3036.

For Office Use Only:
Was this information entered in manually by a DDS employee on behalf of the applicant?

☐ Yes
☐ No

2025.09.V3.1

[Submit](#)

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") *

[Select files...](#)



✓ Done

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

2025.09.V3.1

[Submit](#)

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 physician is currently reviewing the form.

	Traumatic Brain Injury Fund Application	
Submission Confirmation		
<p>Hello Jane Doe,</p>		
<p>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.</p>		
<p>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.</p>		
<p>ACTION REQUIRED: None</p>		
<p>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</p>		
<p><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></p>		

An email notification is sent to the requester, notifying them that it is now in the process of being reviewed by their physician.



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 there is a **Request for More Information**.

1. Select **Review Online**. Your filled out form is displayed. Please make all the requested changes and provide your signature once completed.

Note: The TBIF Department Comments are displayed in the email notification.



Traumatic Brain Injury Fund Application



TBI Fund Request for Additional Information

Hello Jane Doe,

This is to notify you that additional information is needed to complete the review of your application TBI-APP-000304. Please provide the requested information within 30 days of this notification (notification date is 08/13/2025).

ACTION REQUIRED: [Review Online](#) the attached form for the request for additional information from TBI team. Please refer to the comments below:

TBIF Department Comments: Attach medical documents.

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

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Note: The Upload Medical Document(s) is only displayed if more information is required.

Medical Information

Year most recent TBI occurred (yyyy) *	Date TBI occurred (mm/dd)	Cause of TBI *
2024	12/27	fall

Treatment received for TBI *


physical therapy

Upload Medical Document(s)

Select files...


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

Note: Your application is cancelled after 30 days if your physician has not submitted their evaluation 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 or call 1-888-285-3036

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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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