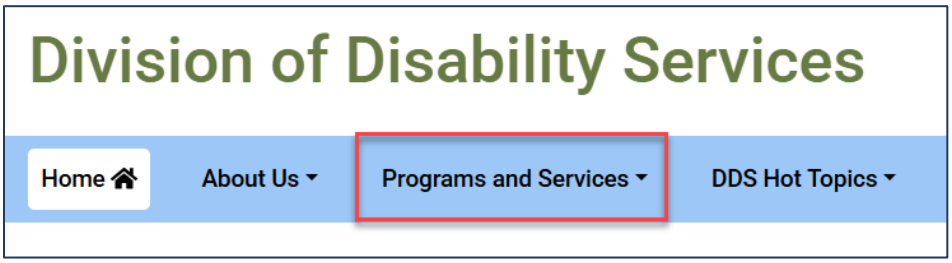
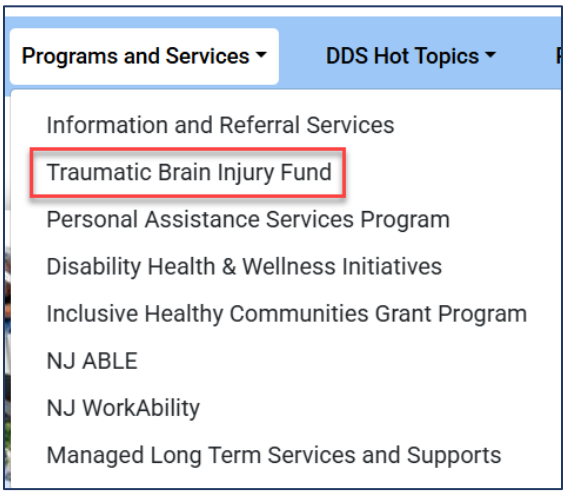
Filling Out the Form

The following guide provides examples of the TBI form filled out. All the information provided in this guide is just for example purposes only. All sections display each section prior to filling it out.

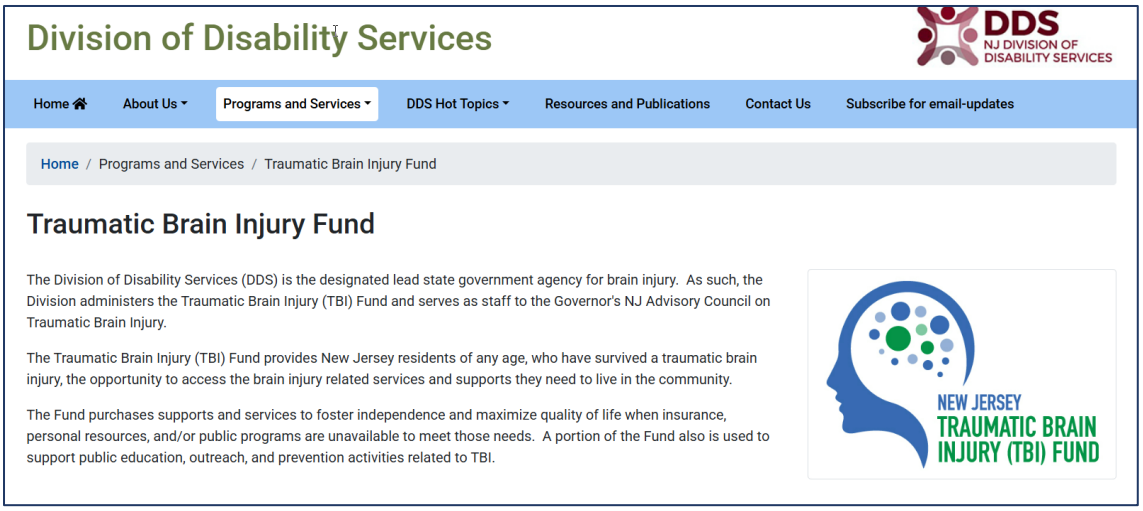
1. Navigate to the Division of Disability Services Homepage: [Division of Disability Services | Home]
2. Select the **Program and Services** drop-down menu.



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

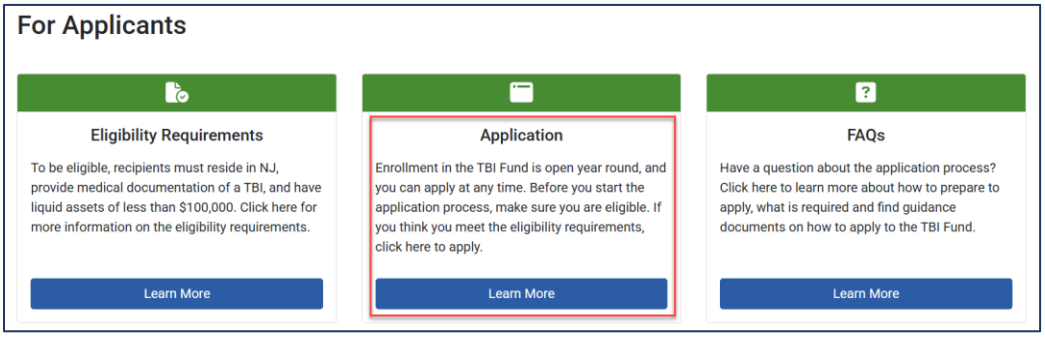


The **Traumatic Brain Injury Fund** homepage is displayed:



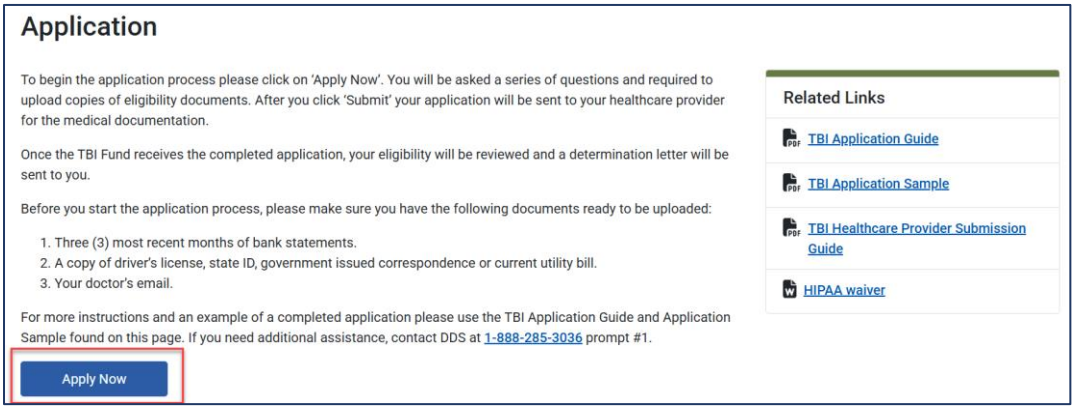
4. Scroll down to **Highlighted Resources**.
5. Select **LEARN MORE** under **For Applicants**.

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



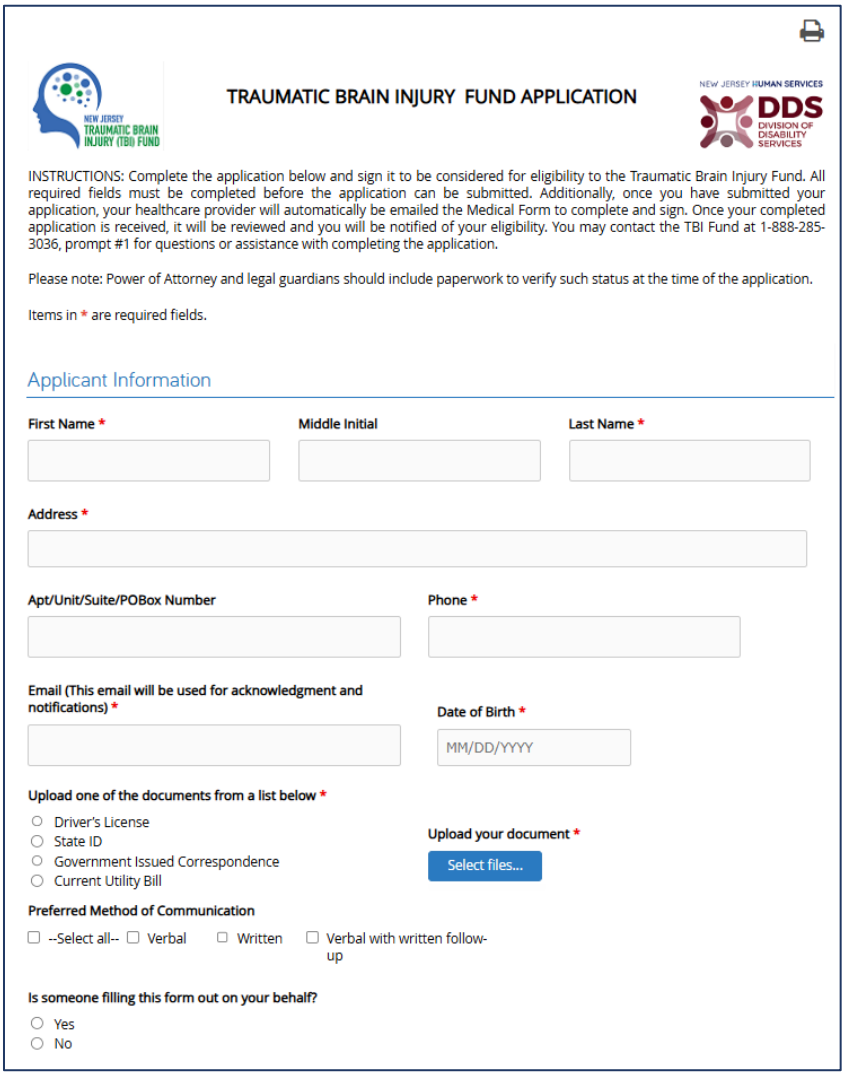
7. Select **Apply Now**.

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

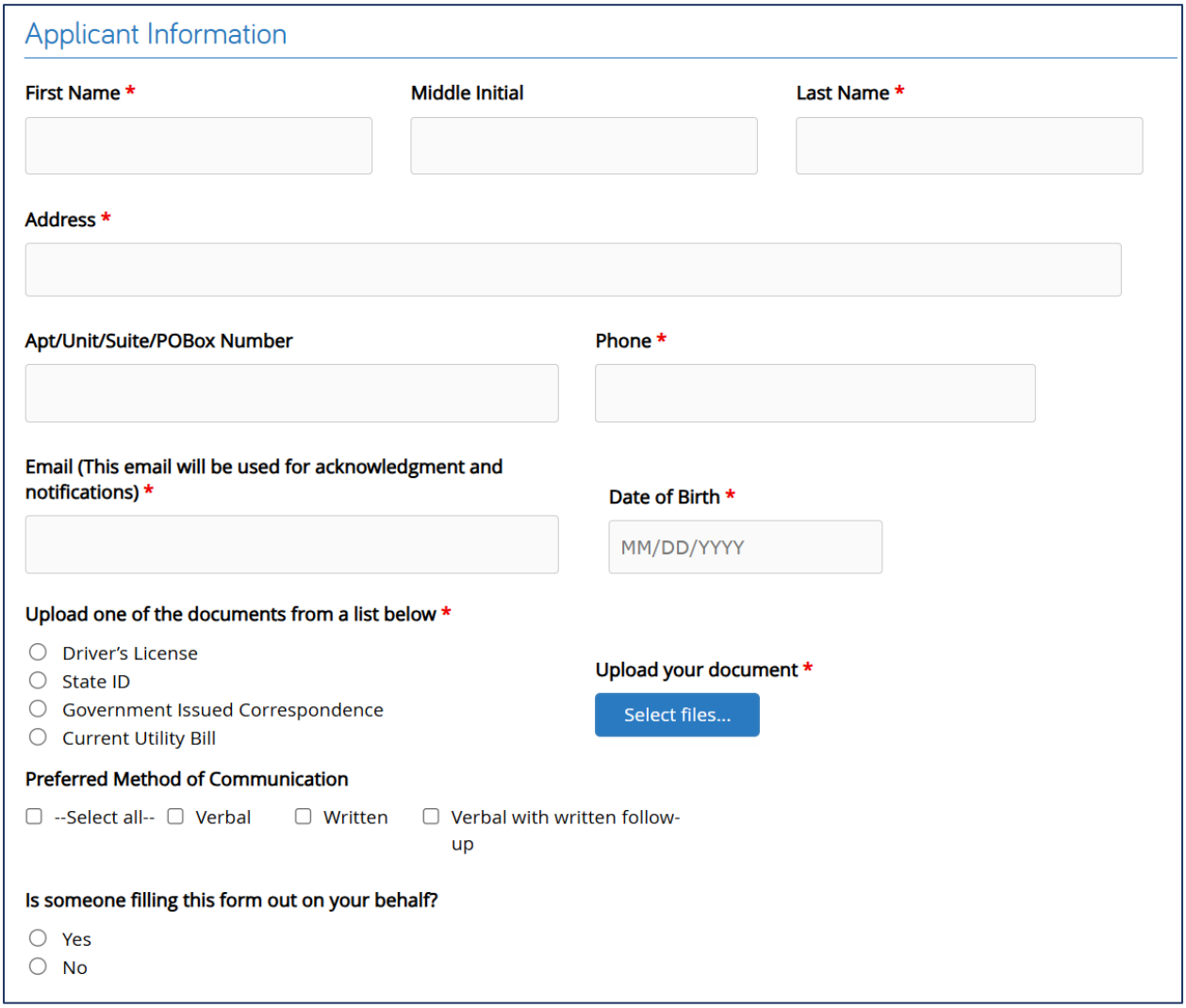


The following form is displayed:

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



Applicant 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

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...

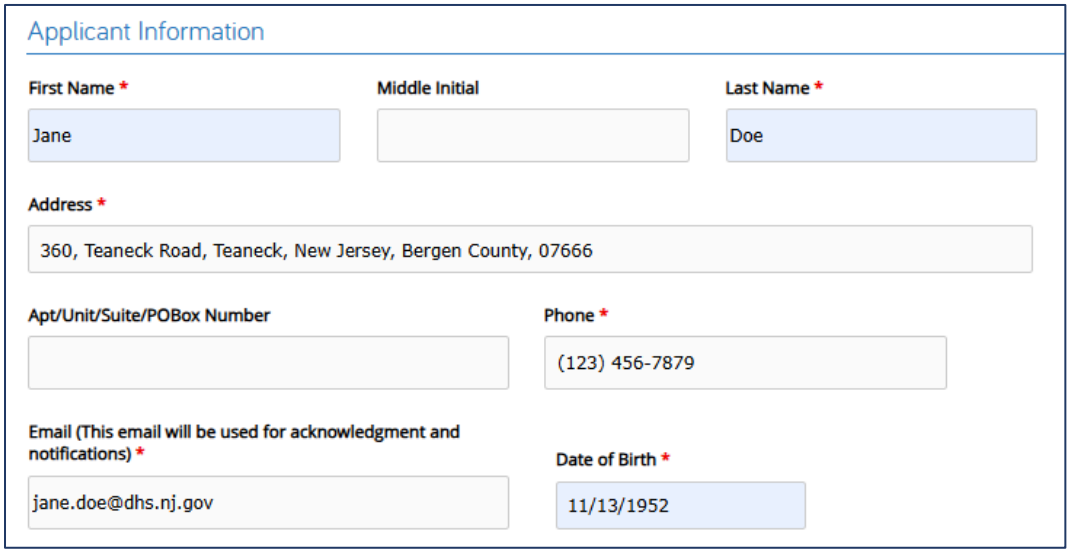
Preferred Method of Communication

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

Is someone filling this form out on your behalf?

- Yes
- No

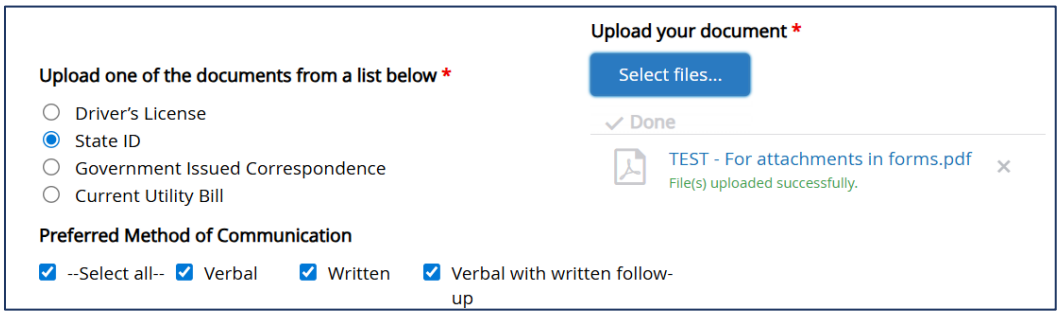
1. Enter the required information.



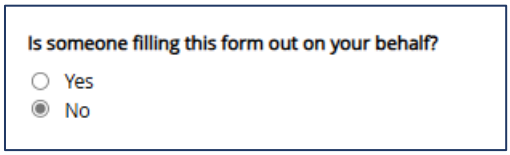
2. Select a document type from the list to upload.
3. **Upload your document** by selecting, **Select files…**

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

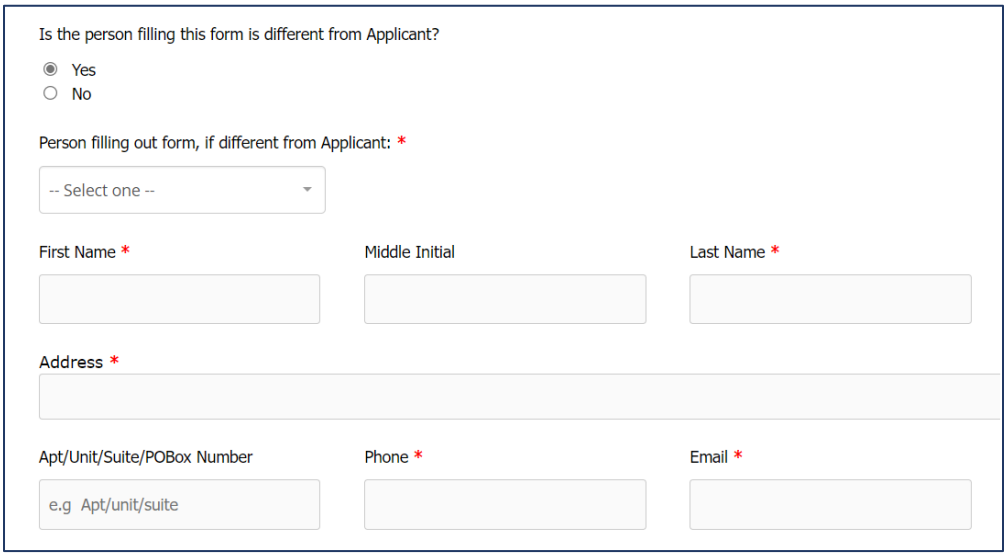
4. Select the relevant information.



5. Select **Yes**, or **No**.

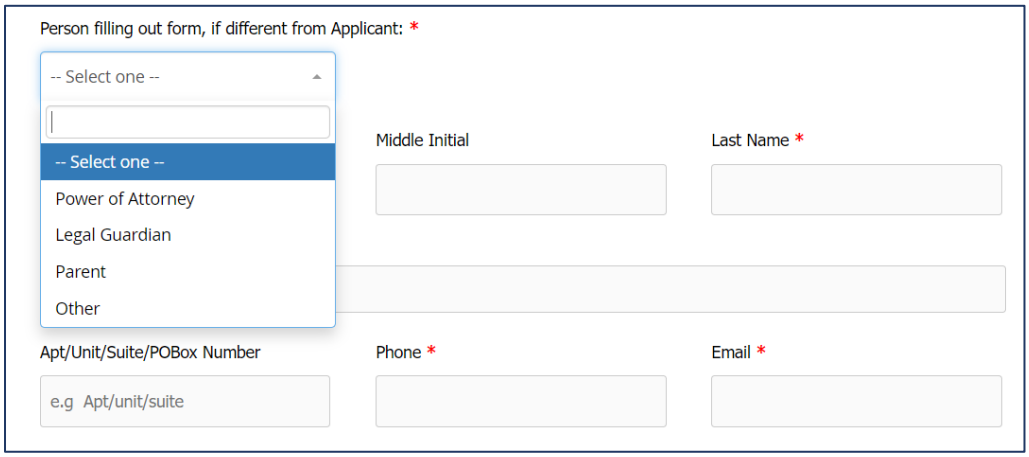


Note: If you selected Yes, an additional section opens. Please follow the process starting at section 2a.



Section 2a

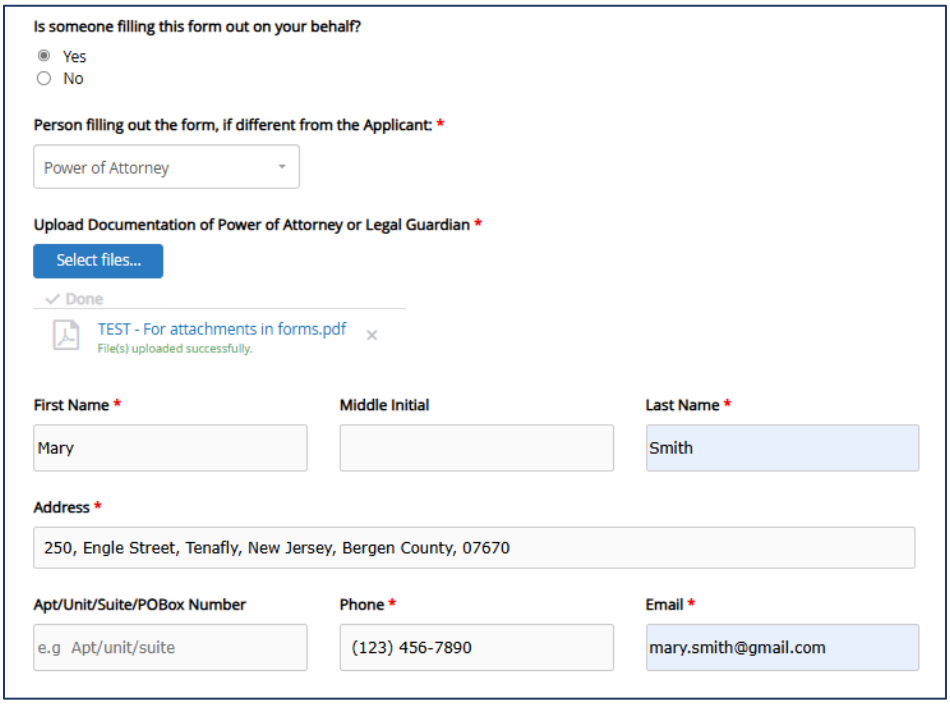
2a Select an option from the drop-down menu.



2b Add the relevant document by selecting, **Select files…**

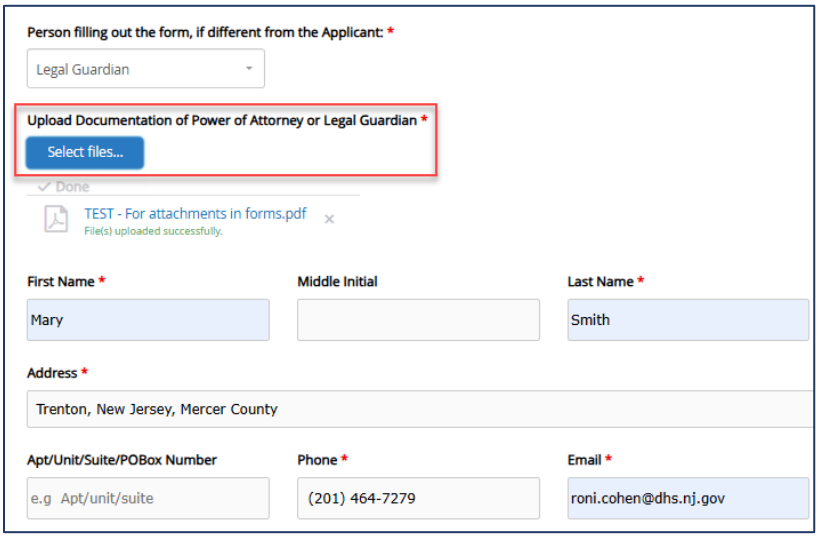
2c Enter the required information.

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.

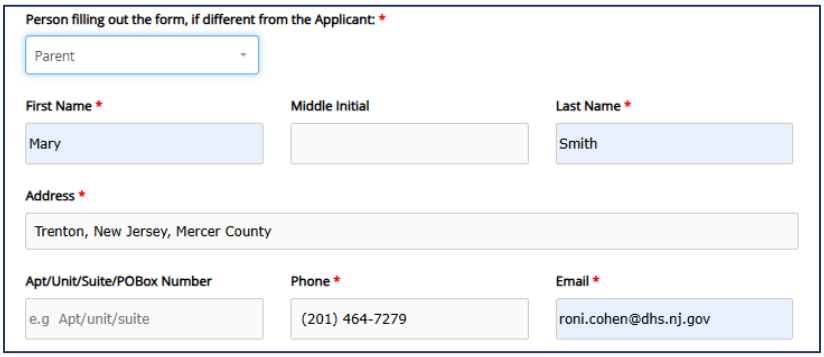


Examples of Options from the Applicant Drop-Down Menu.

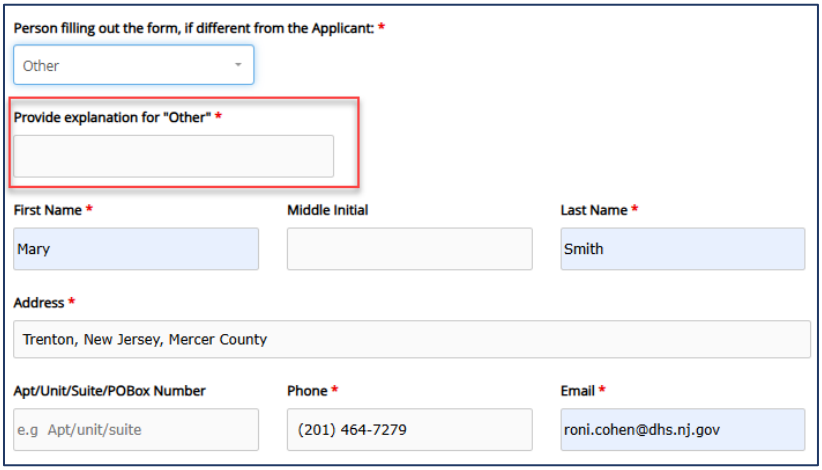
Note: If you selected Yes to Person filling out the form, is different from the Applicant you may have to attach additional documents or provide an explanation.



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

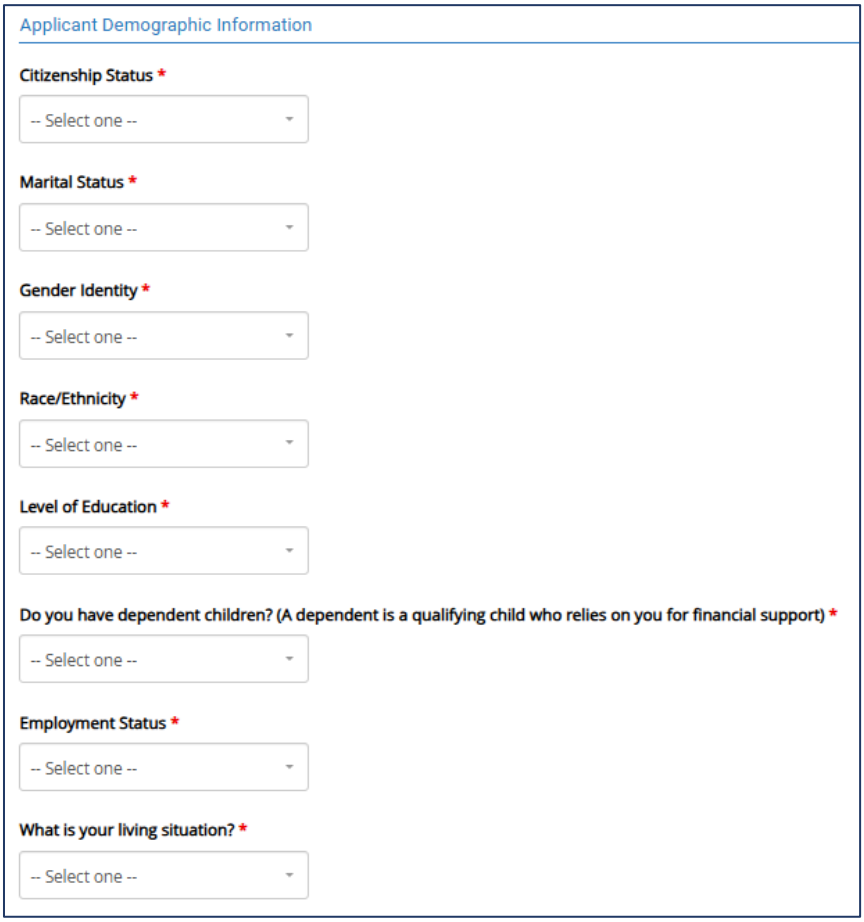


Note: If you select Other, an additional field is displayed.



Applicant Demographic Information

Please provide the required information.

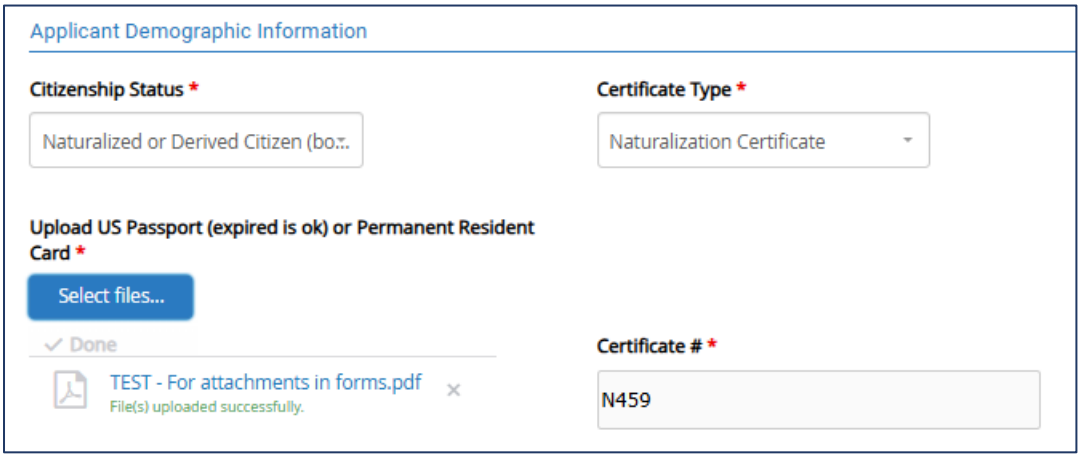


Filling Out the Applicant Demographic Information

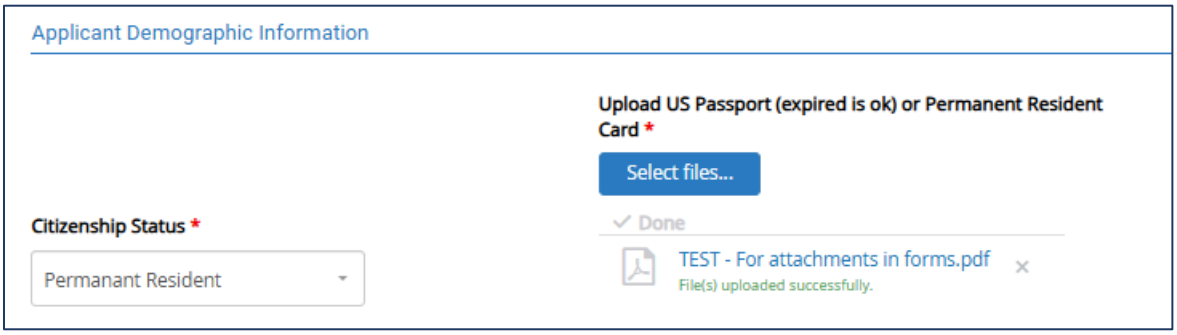
Note: The examples in this section display fields that require more information.

1. Select an option from the **Citizenship Status** drop-down menu.
2. Upload the required documents by selecting, **Select files..** Enter additional information.

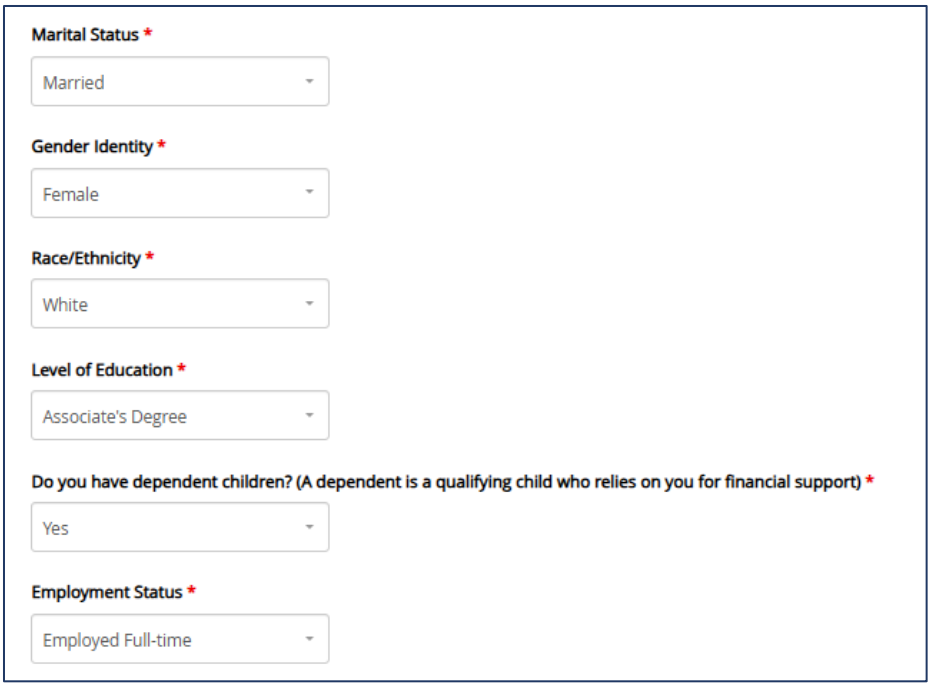
Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document,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



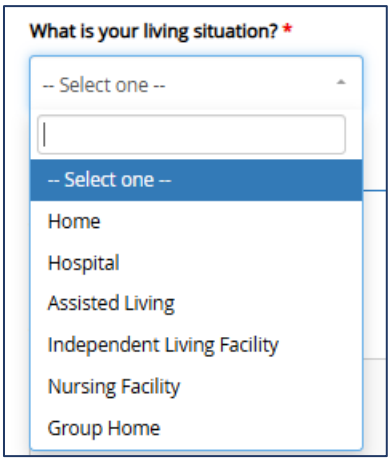
or



3. Select an option from the drop-down menus.

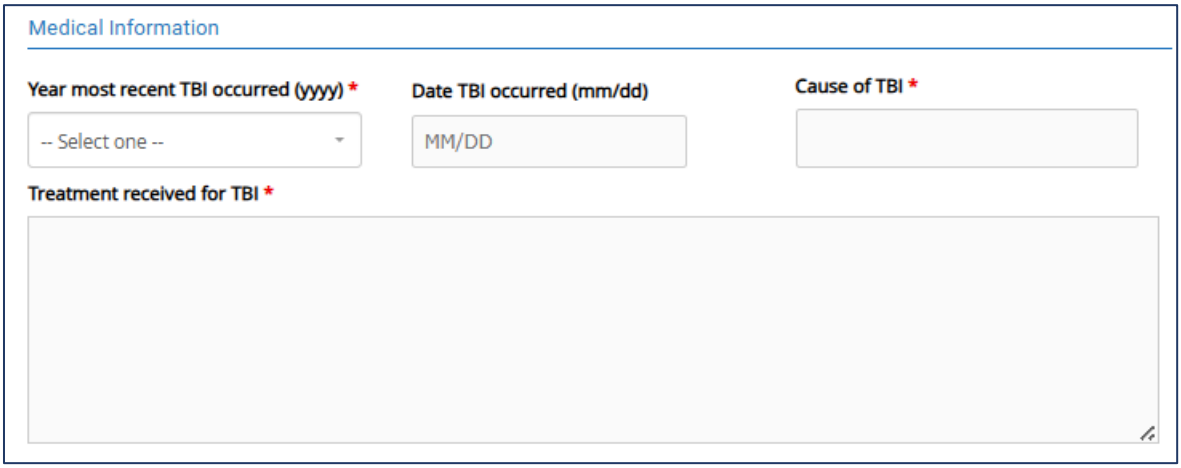


4. Select an option from the **What is your living situation?**



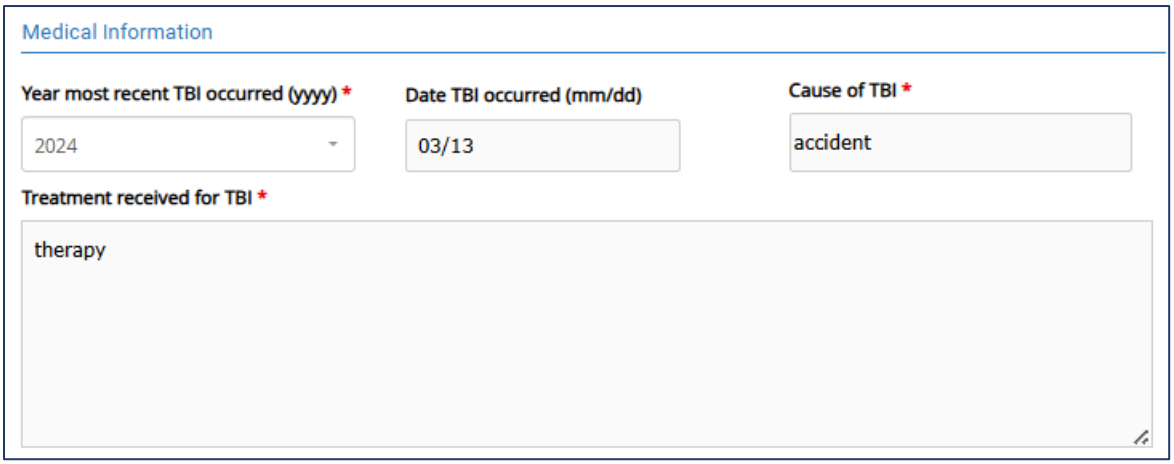
Note: If you select Home from the drop-down menu, you have to select Own or Rent.

Medical Information

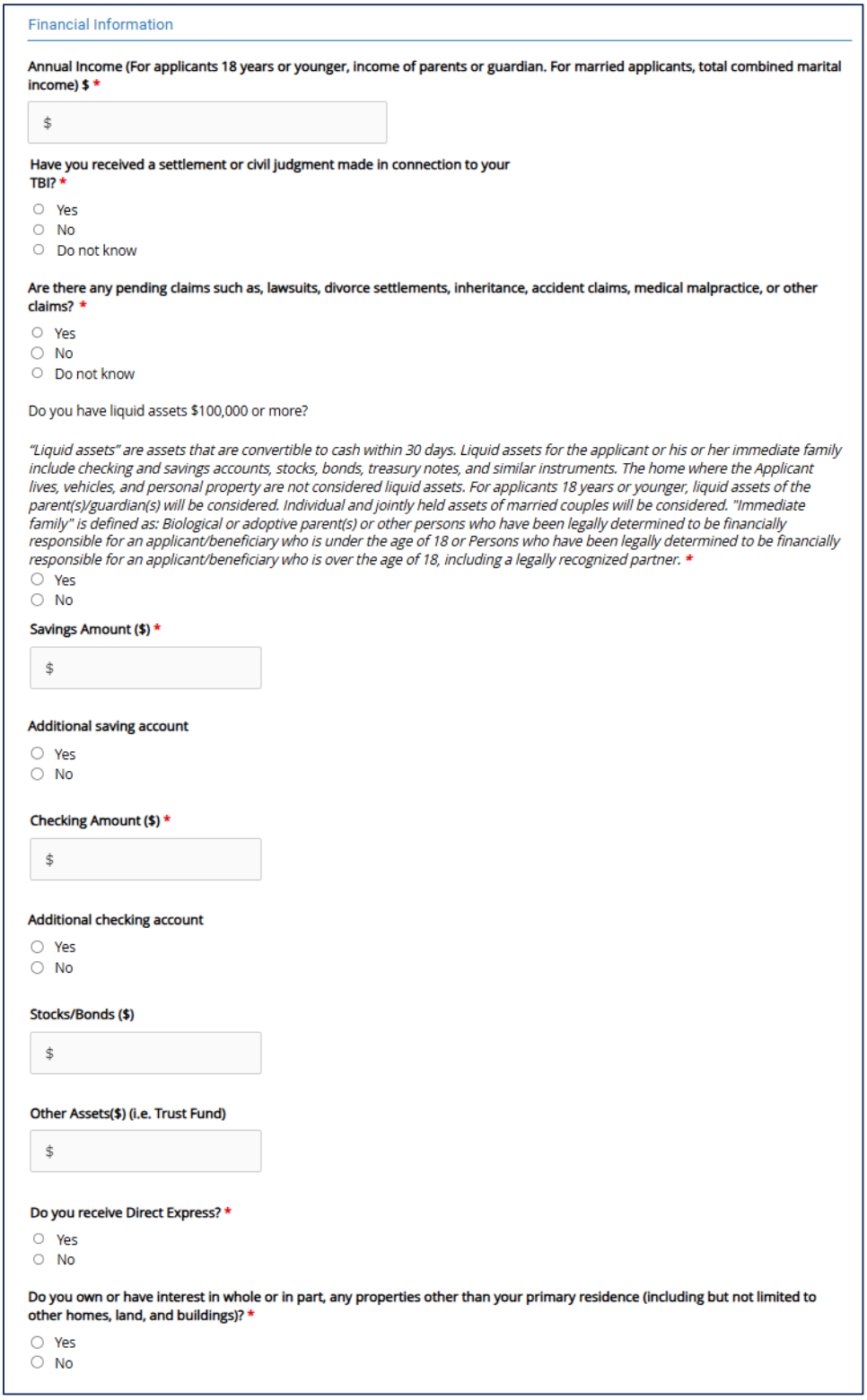


Filling Out Medical Information

1. Select the **Year most recent TBI occurred (yyyy)**.
2. Enter the required information.



Financial Information



Financial Information

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

$

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

- Yes
- No
- 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

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

Stocks/Bonds ($)

$

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

$

Do you receive Direct Express? *

- Yes
- No

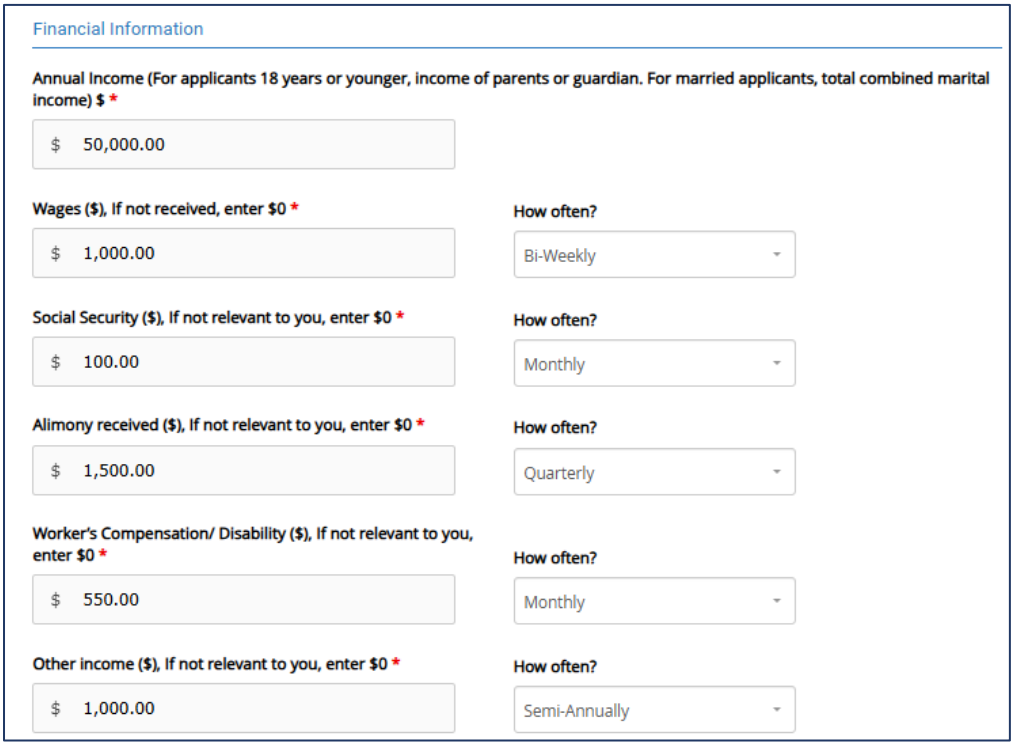
Do you own or have interest in whole or in part, any properties other than your primary residence (including but not limited to other homes, land, and buildings)? *

- Yes
- No

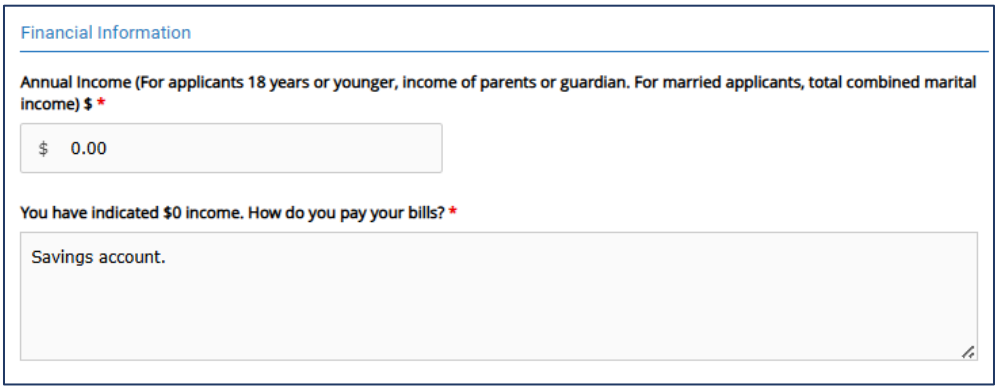
Filling Out Financial Information

Note: The additional fields are displayed once you enter your Income.

1. Enter your **Annual Income**.

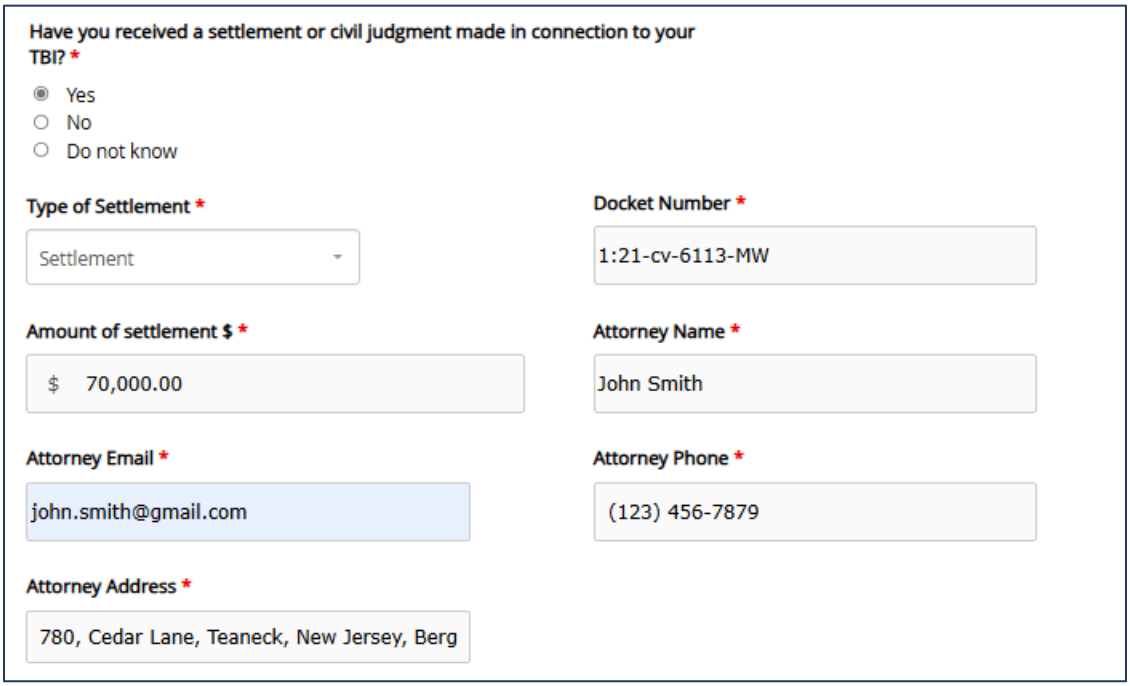


Note: If you enter 0 for your Annual Income an additional field is displayed. Please provide an explanation.

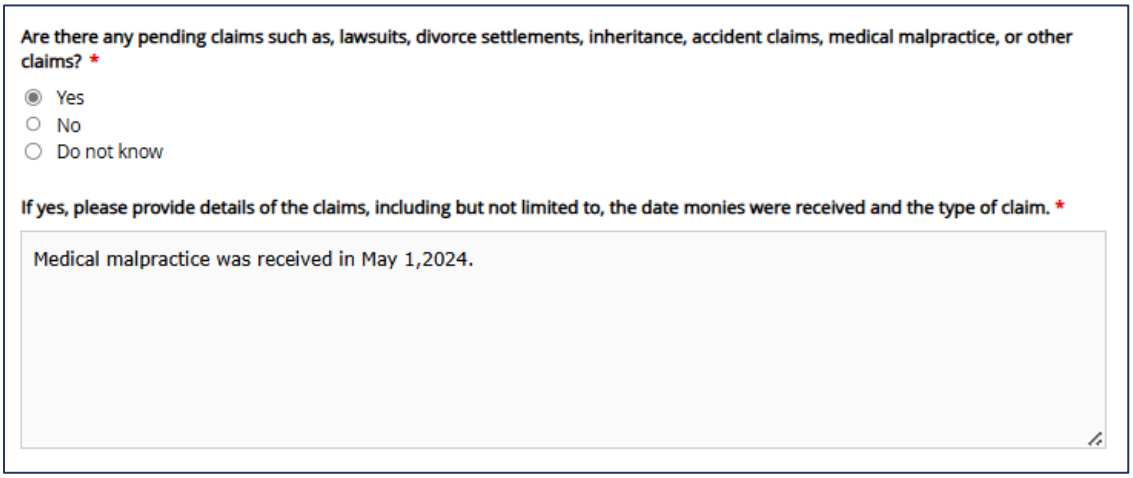


Note: All the information that is displayed in the screenshots are only examples. There is no real information provided.

2. Select **Yes, No**, or **Do not know**. If **Yes**, please provide details.



3. Select **Yes, No**, or **Do not know**. If **Yes**, please provide details.

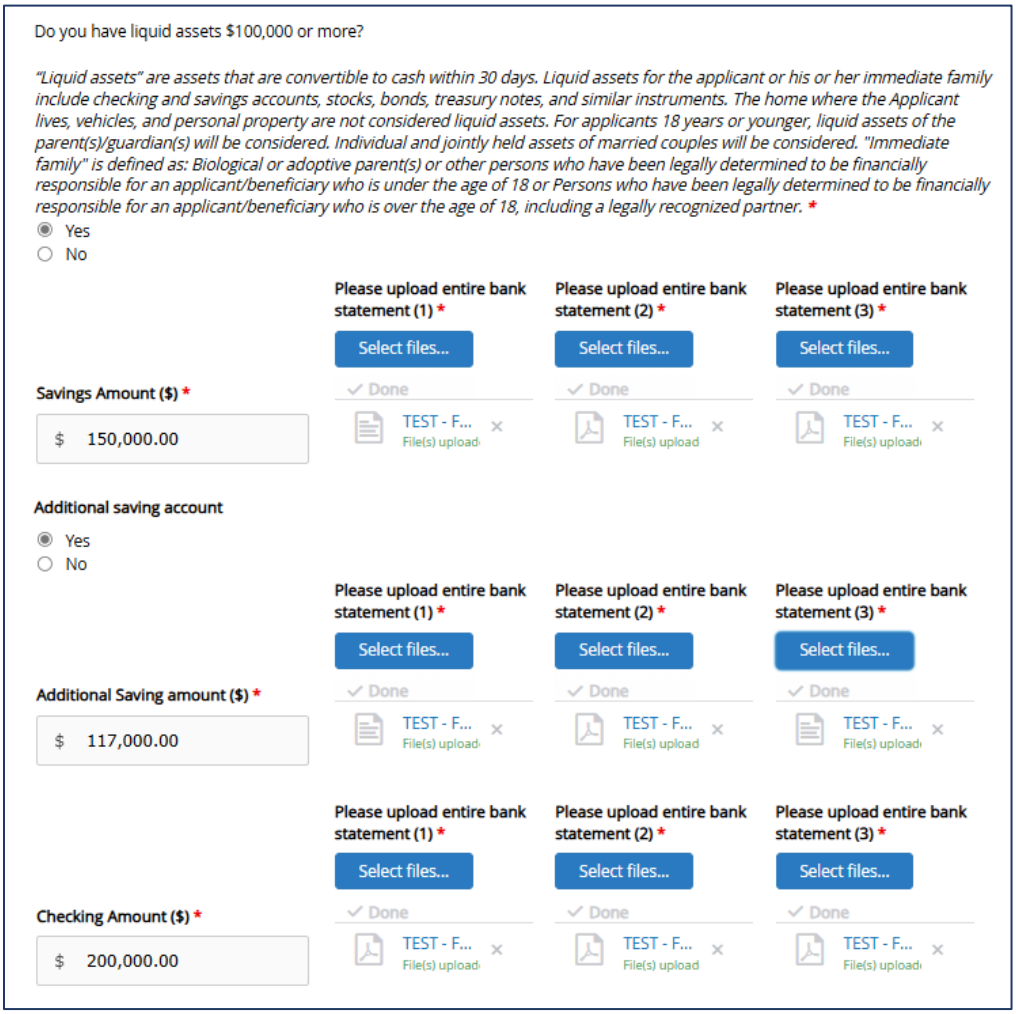


4. Enter all **liquid assets that are $100,000 or more**.

Note: Once you enter an amount in any of the Accounts fields, the Select files… are displayed.

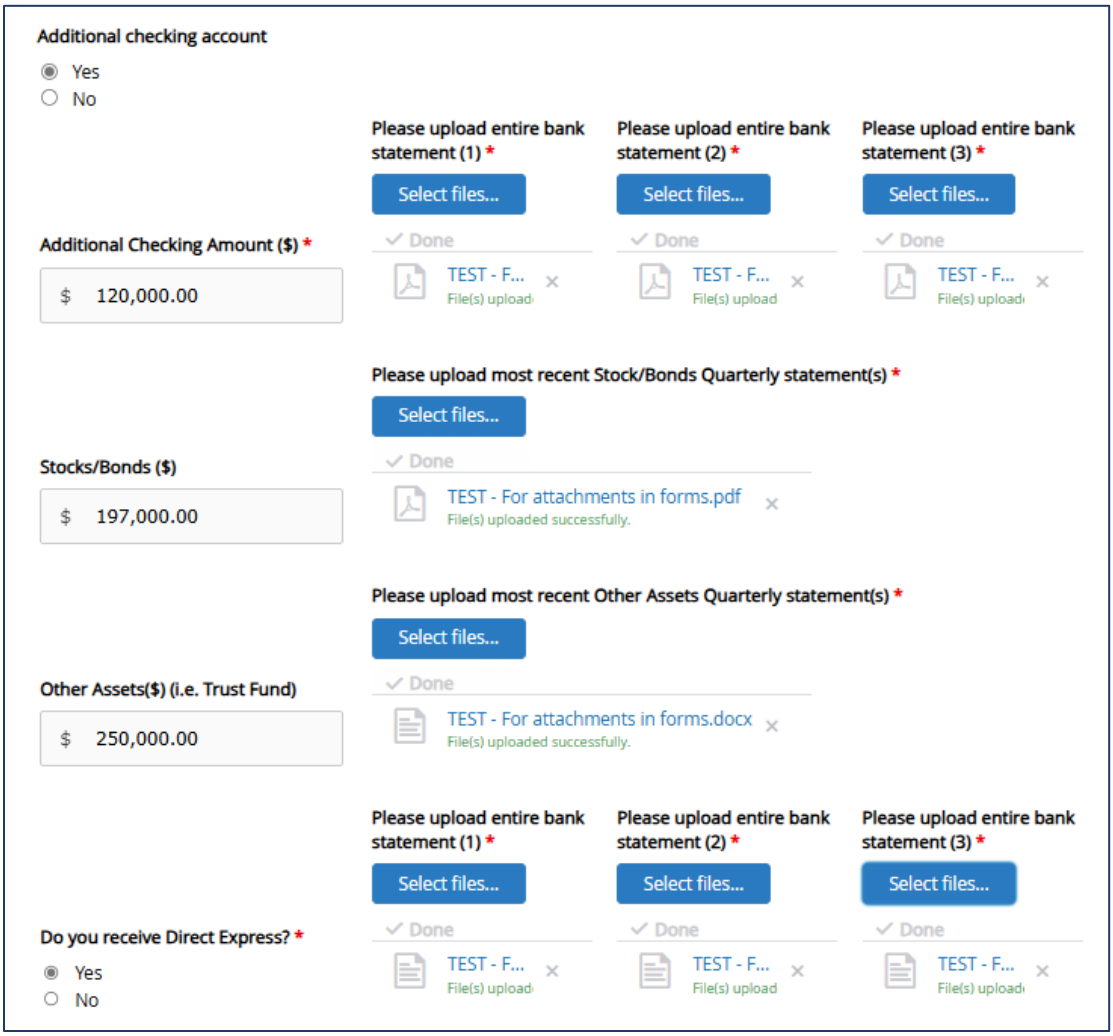
5. Attach all required documents.

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.



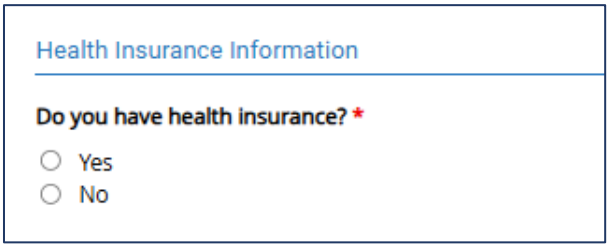
6. Enter the required information.

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



7. Select **Yes, No**, or **Do not know**. If **Yes**, please provide details.

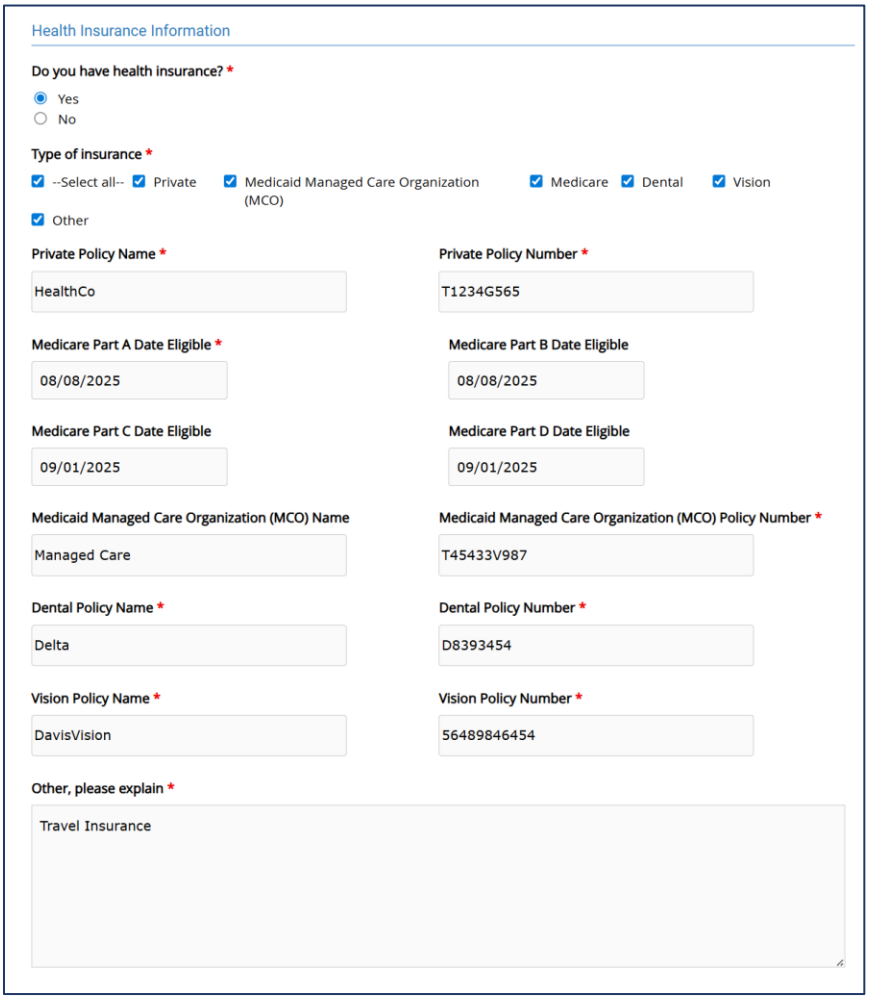
Health Insurance Information



Filling Out Health Insurance Information

Note: All types of insurance are selected just for example purposes.

1. Select **Yes**, or **No**.
2. Select the **Type of Insurance**.
3. Enter the required information about your insurance.



Services Information

Services Information

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

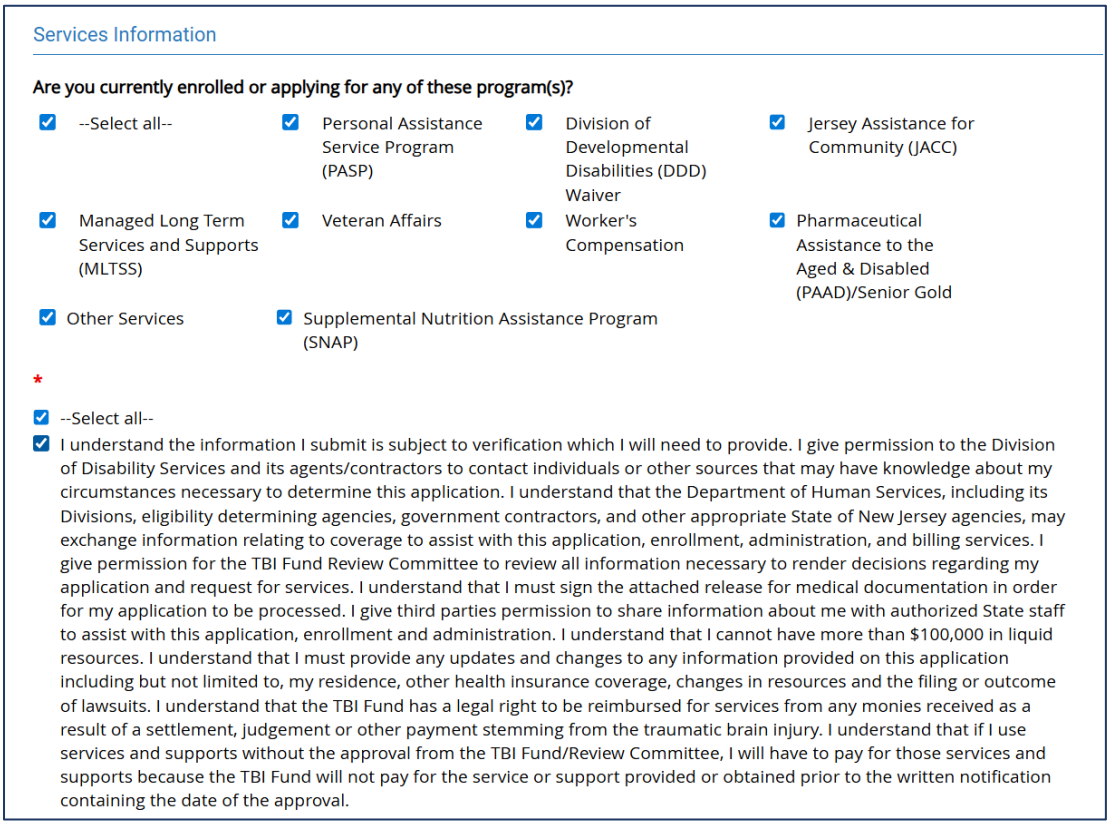
- ☐ --Select all--
- ☐ Personal Assistance Service Program (PASP)
- ☐ Division of Developmental Disabilities (DDD) Waiver
- ☐ Jersey Assistance for Community (JACC)
- ☐ Managed Long Term Services and Supports (MLTSS)
- ☐ Veteran Affairs
- ☐ Worker's Compensation
- ☐ Pharmaceutical Assistance to the Aged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

*

- ☐ --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.

Filling Out Services Information

1. Select the relevant **Services Information**.
2. Select the **I understand the information** box.



Services Information

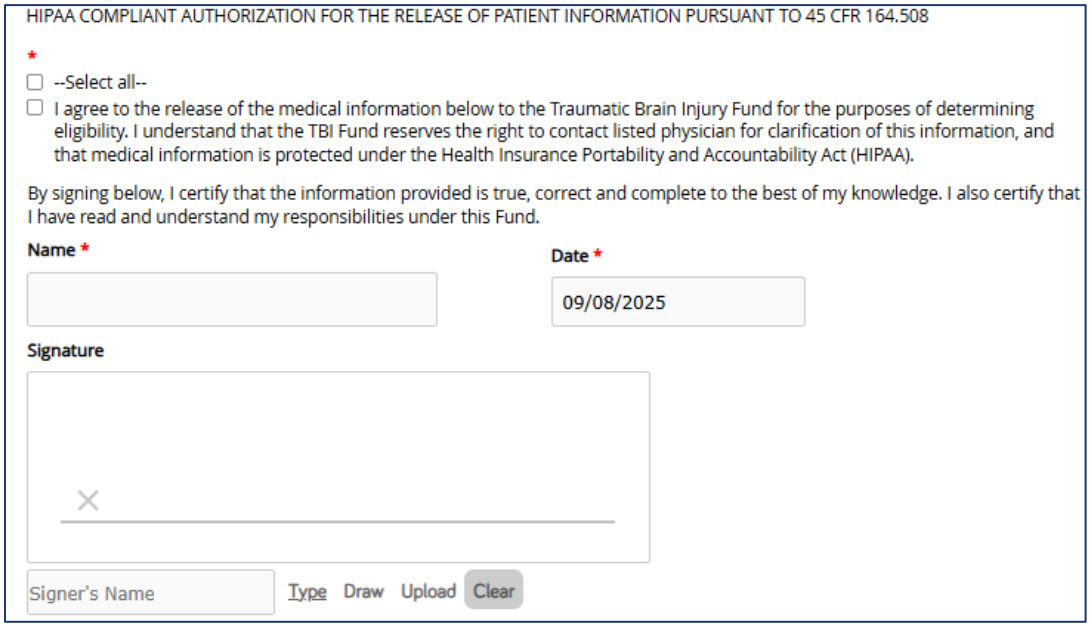
Are you currently enrolled or applying for any of these program(s)?

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

*

- [x] --Select all--
- [x] 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.

HIPAA Compliant Authorization for the Release of Patient



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 *

09/08/2025

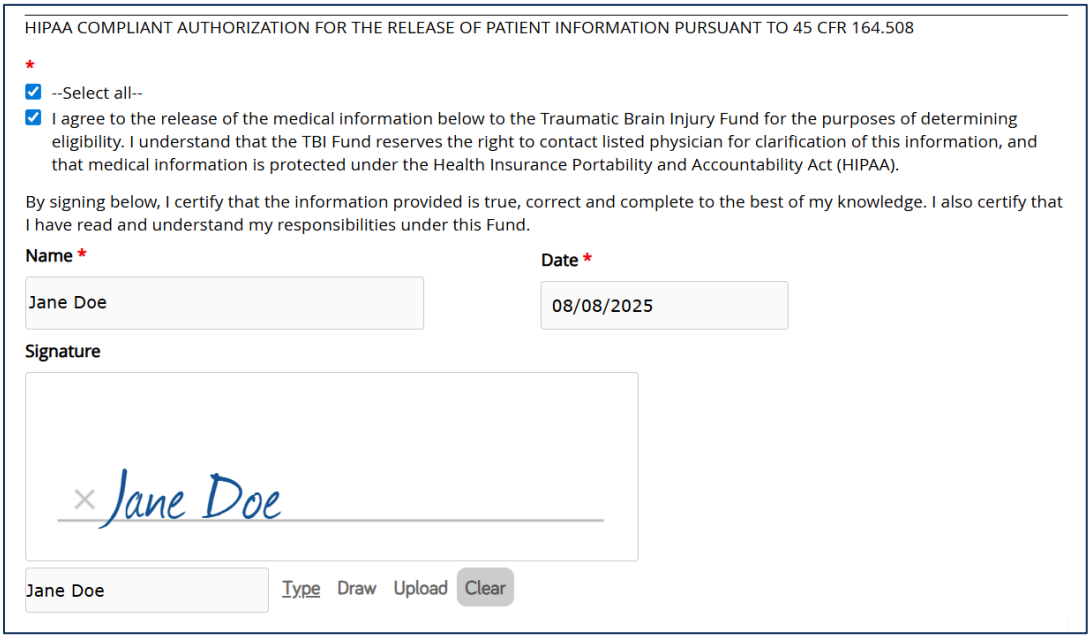
Signature

Signer's Name Type Draw Upload Clear

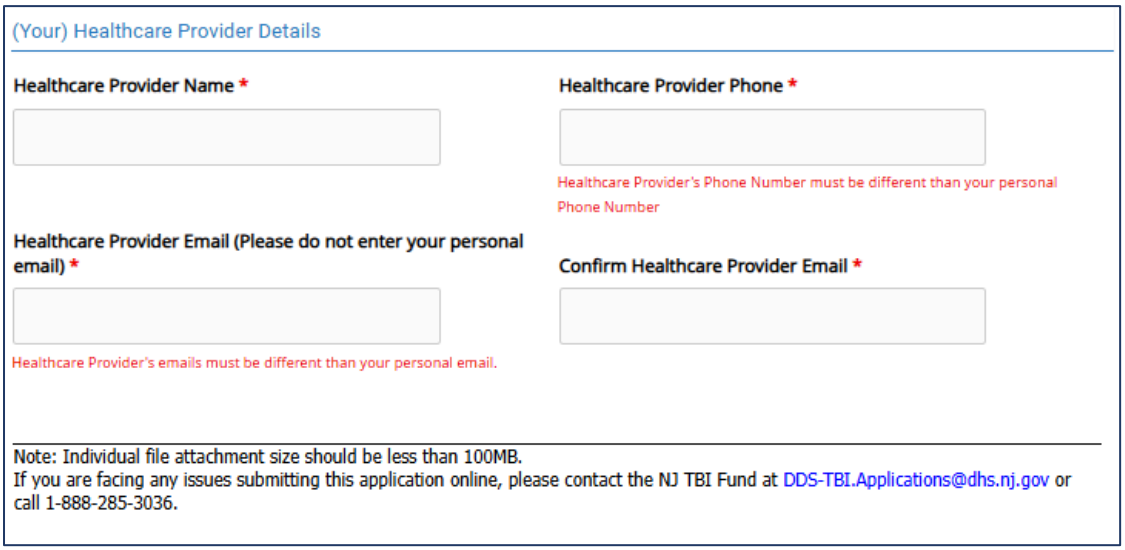
Filling Out HIPAA Compliant Authorization for the Release of Patient

1. Please read the **HIPAA COMPLIANT AUTHOERIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR-164.508.**
2. Select the **I agree** box.
3. **Type, Draw,** or **Upload** your **Signature**.

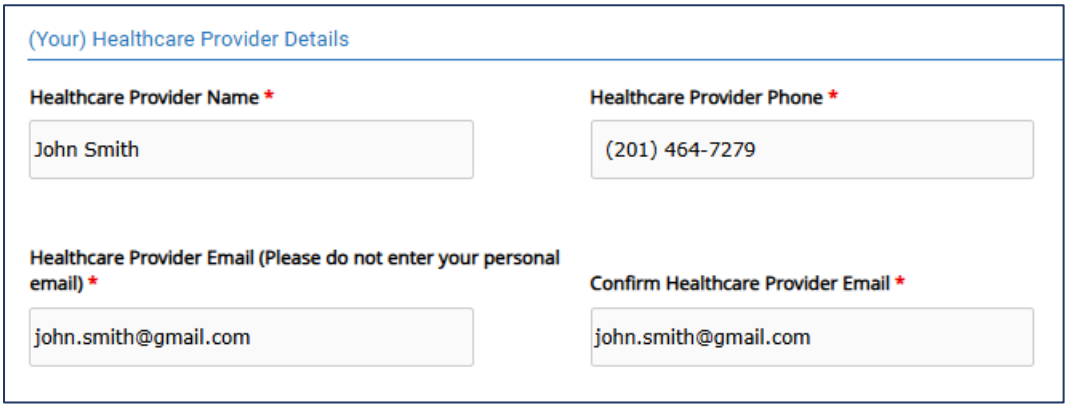
Important: If your documents are not saved on the computer, please scan and save them. Be sure to save the documents in one place that you can remember. Once you select, Select files… A window with folders and saved items is displayed. Navigate to the location with the saved files and add each document,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



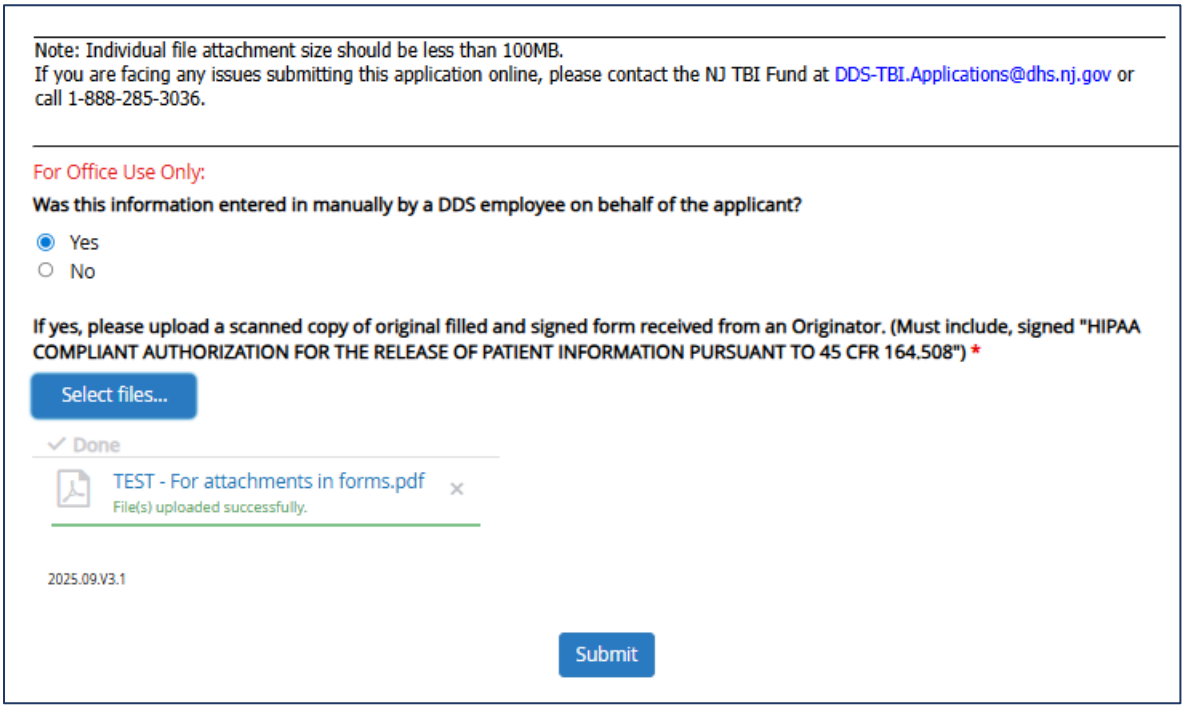
(Your) Healthcare Provider Details



1. Enter the required information.



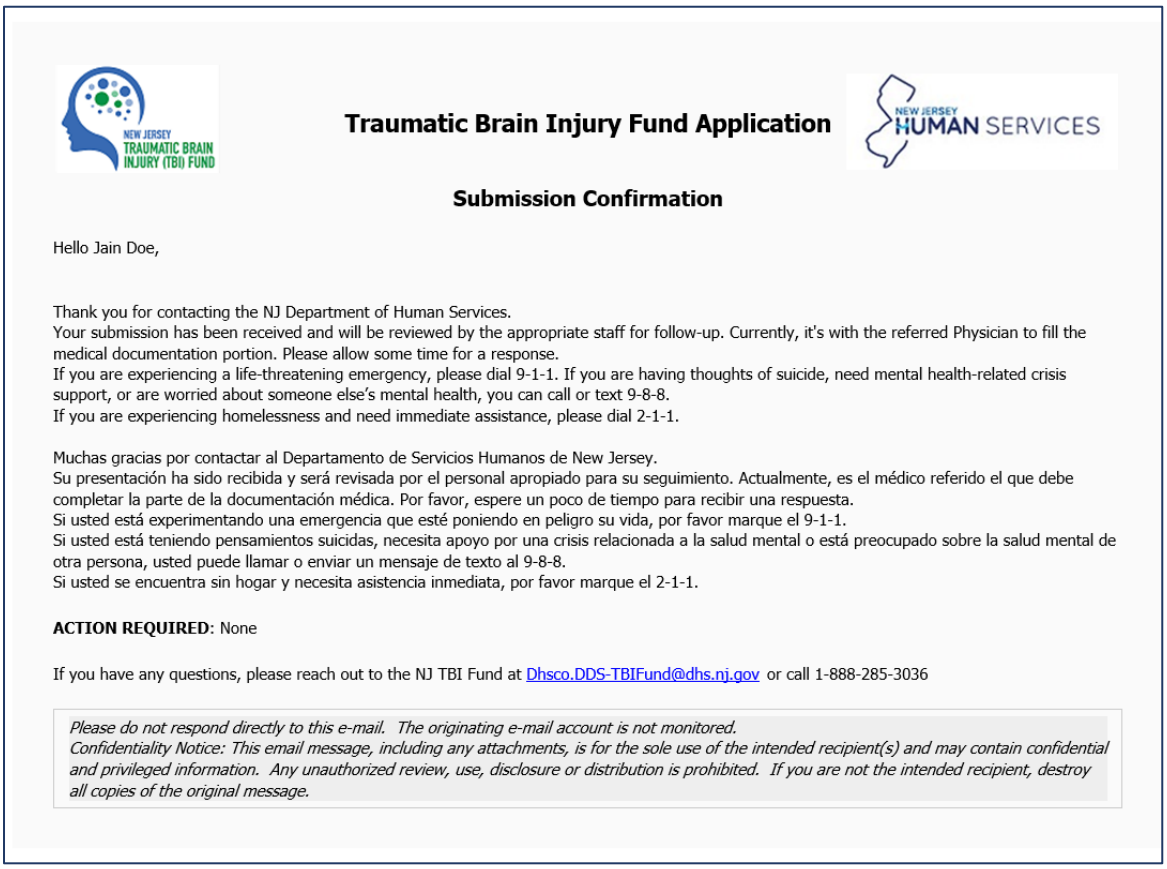
2. Select **Yes,** or **No**. If you select **Yes**, please attach the required document.
3. Select **Save** if you would like to come back to the form at a later time.
4. Select **Submit** once you are ready to complete the form.



Emails to the Requester

The following email notifications keep you updated on your form.

The requester receives the following notification email confirming that a form has been submitted:



Traumatic Brain Injury Fund Application

Submission Confirmation

Hello Jain Doe,

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

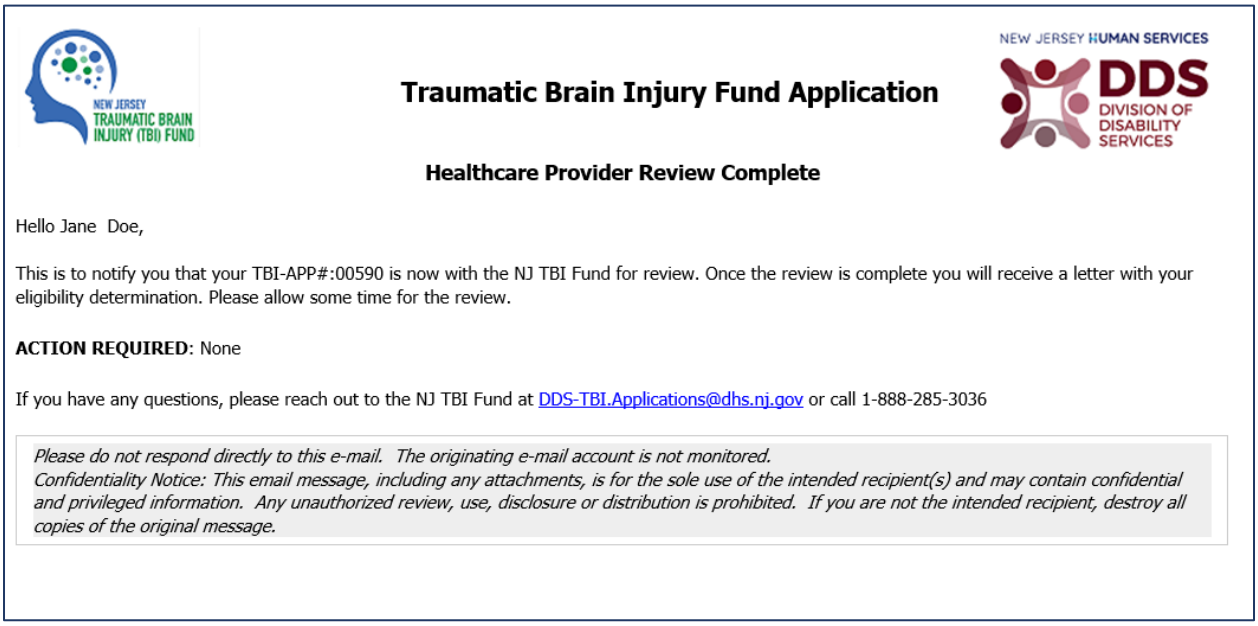
Muchas gracias por contactar al Departamento de Servicios Humanos de New Jersey.
Su presentación ha sido recibida y será revisada por el personal apropiado para su seguimiento. Actualmente, es el médico referido el que debe completar la parte de la documentación médica. Por favor, espere un poco de tiempo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

ACTION REQUIRED: None

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

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

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



NEW JERSEY TRAUMATIC BRAIN INJURY (TBI) FUND

Traumatic Brain Injury Fund Application

NEW JERSEY HUMAN SERVICES DDS DIVISION OF DISABILITY SERVICES

Healthcare Provider Review Complete

Hello Jane Doe,

This is to notify you that your TBI-APP#:00590 is now with the NJ TBI Fund for review. Once the review is complete you will receive a letter with your eligibility determination. Please allow some time for the review.

ACTION REQUIRED: None

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

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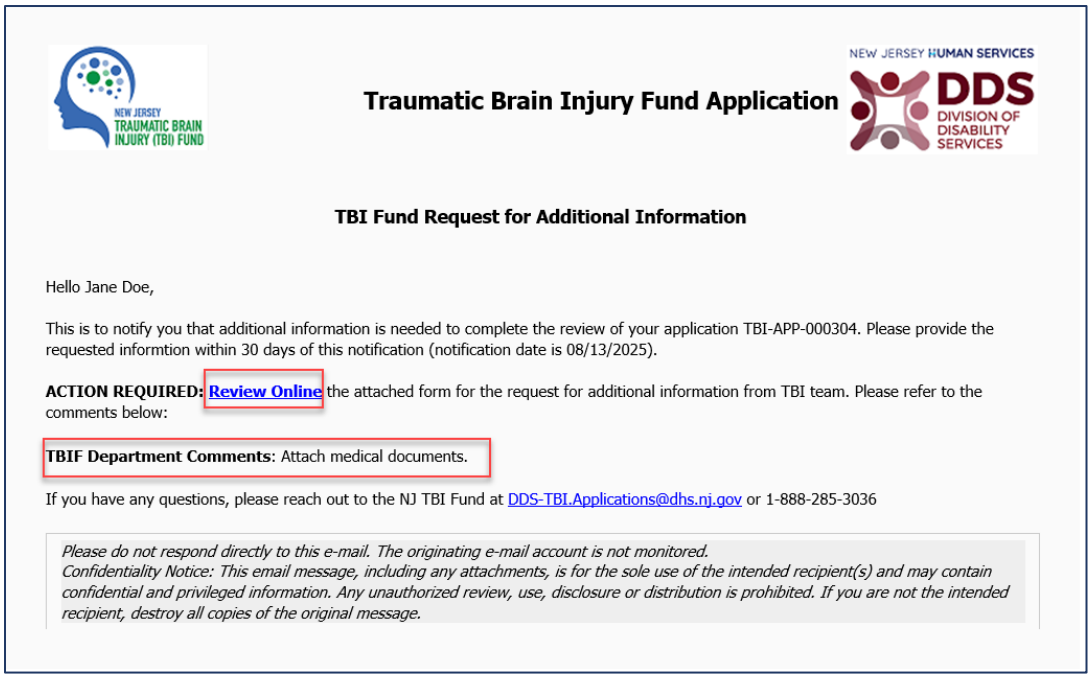
An email notification is sent to the requester, notifying them that there is a **Request for More Information**.

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.



NEW JERSEY TRAUMATIC BRAIN INJURY (TBI) FUND

Traumatic Brain Injury Fund Application

NEW JERSEY HUMAN SERVICES DDS DIVISION OF DISABILITY SERVICES

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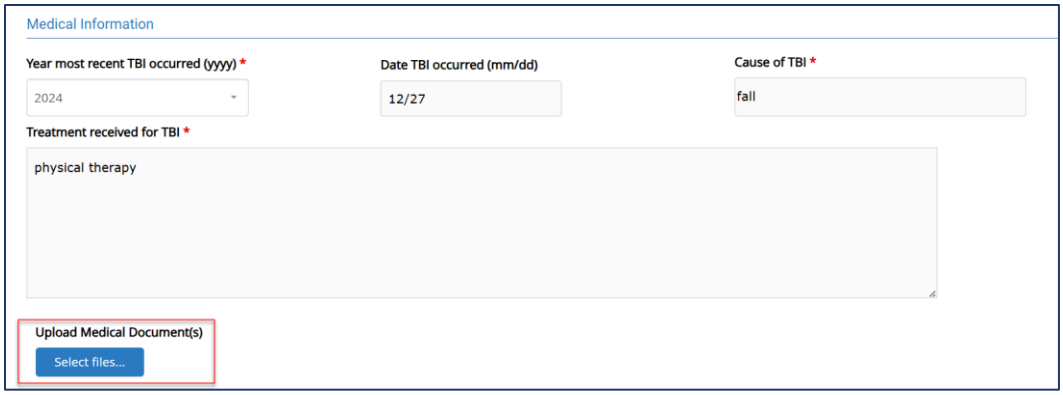
Note: The Upload Medical Document(s) is only displayed if more information is required.



Medical Information

Year most recent TBI occurred (yyyy) *: 2024

Date TBI occurred (mm/dd): 12/27

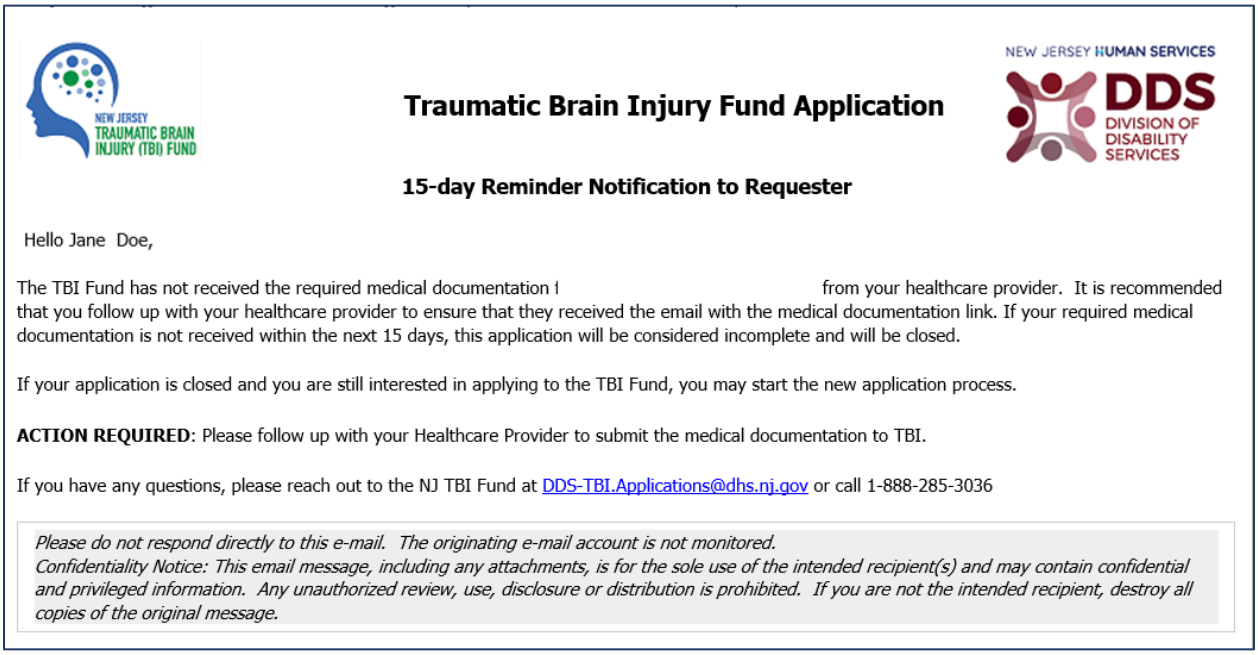
Cause of TBI *: fall

Treatment received for TBI *: physical therapy

Upload Medical Document(s)

Select files...

An email notification is sent to the requester, notifying them that their healthcare provider has not provided the medical documentation needed; you receive the following email notification.



NEW JERSEY TRAUMATIC BRAIN INJURY (TBI) FUND

Traumatic Brain Injury Fund Application

NEW JERSEY HUMAN SERVICES DDS DIVISION OF DISABILITY SERVICES

15-day Reminder Notification to Requester

Hello Jane Doe,

The TBI Fund has not received the required medical documentation f 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 the 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 start the new 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 DDS-TBI.Applications@dhs.nj.gov or call 1-888-285-3036

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