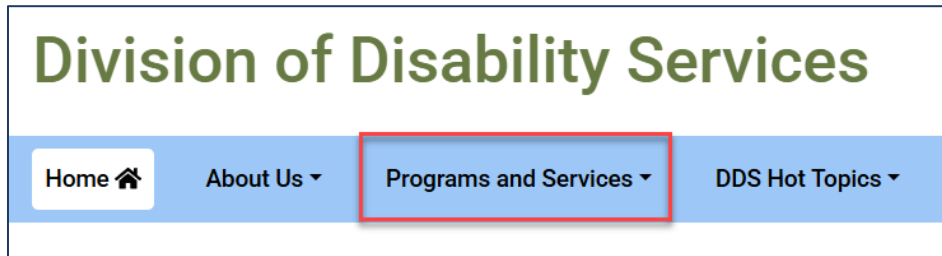


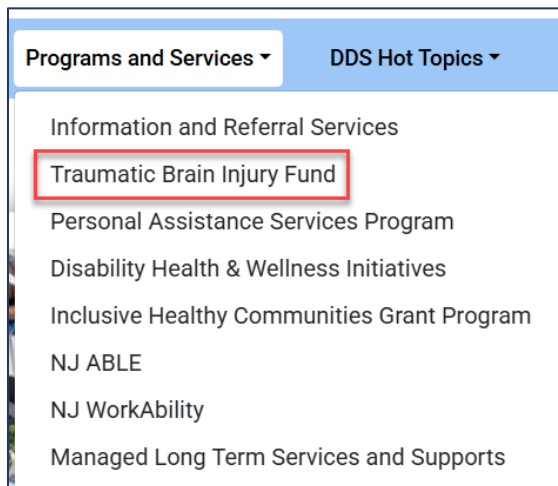
Filling Out the Form

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:

Division of Disability Services

[Home](#)
[About Us](#)
[Programs and Services](#)
[DDS Hot Topics](#)
[Resources and Publications](#)
[Contact Us](#)
[Subscribe for email-updates](#)

[Home](#) / [Programs 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.




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

Highlighted Resources




For Applicants

[LEARN MORE >](#)




For Providers

[LEARN MORE >](#)



Resources

[LEARN MORE >](#)




Meetings

[LEARN MORE >](#)

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


For Applicants



Eligibility Requirements

To be eligible, recipients must reside in NJ, provide medical documentation of a TBI, and have liquid assets of less than \$100,000. Click here for more information on the eligibility requirements.


[Learn More](#)



Application

Enrollment in the TBI Fund is open year round, and you can apply at any time. Before you start the application process, make sure you are eligible. If you think you meet the eligibility requirements, click here to apply.

[Learn More](#)



FAQs

Have a question about the application process? Click here to learn more about how to prepare to apply, what is required and find guidance documents on how to apply to the TBI Fund.

[Learn More](#)

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



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 *
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address *

Apt/Unit/Suite/POBox Number	Phone *
<input type="text"/>	<input type="text"/>

Email (This email will be used for acknowledgment and notifications) *	Date of Birth *
<input type="text"/>	<input type="text" value="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 *

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

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

1. Enter the required information.

Applicant Information

First Name *

Middle Initial

Last Name *

Jane

Doe

Address *

360, Teaneck Road, Teaneck, New Jersey, Bergen County, 07666

Apt/Unit/Suite/POBox Number

Phone *

(123) 456-7879

Email (This email will be used for acknowledgment and notifications) *

Date of Birth *

jane.doe@dhs.nj.gov

11/13/1952

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.

Upload one of the documents from a list below *

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

Preferred Method of Communication

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

Upload your document *

Select files...

✓ Done

TEST - For attachments in forms.pdf

File(s) uploaded successfully.

5. 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 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 *
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address *

Apt/Unit/Suite/POBox Number	Phone *	Email *
<input type="text"/> 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 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 *

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.

Is someone filling this form out on your behalf?

☒ Yes
☐ No

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

Power of Attorney

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 *

250, Engle Street, Tenafly, New Jersey, Bergen County, 07670

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

e.g Apt/unit/suite (123) 456-7890 mary.smith@gmail.com

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

Applicant Demographic Information

Please provide the required information.

Applicant Demographic Information

Citizenship Status *

-- Select one --

Marital Status *

-- Select one --

Gender Identity *

-- Select one --

Race/Ethnicity *

-- Select one --

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 --

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.

Applicant Demographic Information

Citizenship Status *

Naturalized or Derived Citizen (bo...

Certificate Type *

Naturalization Certificate

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

Select files...

✓ Done

TEST - For attachments in forms.pdf

File(s) uploaded successfully.

Certificate # *

N459

or

Applicant Demographic Information

Citizenship Status *

Permanent Resident

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

Select files...

✓ Done

TEST - For attachments in forms.pdf

File(s) uploaded successfully.

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

Marital Status *

Married

Gender Identity *

Female

Race/Ethnicity *

White

Level of Education *

Associate's Degree

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

Yes

Employment Status *

Employed Full-time

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

What is your living situation? *

-- Select one --

-- Select one --

Home

Hospital

Assisted Living

Independent Living Facility

Nursing Facility

Group Home

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

What is your living situation? *

Home

Own or Rent? *

☐ Own

☒ Rent

Medical Information

Medical Information

Year most recent TBI occurred (yyyy) *

Date TBI occurred (mm/dd)

Cause of TBI *

-- Select one --

MM/DD

Treatment received for TBI *

Filling Out Medical Information

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

Medical Information

Year most recent TBI occurred (yyyy) *

Date TBI occurred (mm/dd)

Cause of TBI *

2024

03/13

accident

Treatment received for TBI *

therapy

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**.

Financial Information

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

\$ 50,000.00

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

\$ 1,000.00

How often?

Bi-Weekly

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

\$ 100.00

How often?

Monthly

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

\$ 1,500.00

How often?

Quarterly

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

\$ 550.00

How often?

Monthly

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

\$ 1,000.00

How often?

Semi-Annually

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

Financial Information

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? *

Savings account.

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.

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

☒ Yes
☐ No
☐ Do not know

Type of Settlement *

Settlement

Docket Number *

1:21-cv-6113-MW

Amount of settlement \$ *

\$ 70,000.00

Attorney Name *

John Smith

Attorney Email *

john.smith@gmail.com

Attorney Phone *

(123) 456-7879

Attorney Address *

780, Cedar Lane, Teaneck, New Jersey, Berg

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

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. *

Medical malpractice was received in May 1,2024.

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.

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

	Please upload entire bank statement (1) *	Please upload entire bank statement (2) *	Please upload entire bank statement (3) *
Savings Amount (\$) * <input type="text" value="\$ 150,000.00"/>	<input type="button" value="Select files..."/> ✓ Done TEST - F... x <small>File(s) upload</small>	<input type="button" value="Select files..."/> ✓ Done TEST - F... x <small>File(s) upload</small>	<input type="button" value="Select files..."/> ✓ Done TEST - F... x <small>File(s) upload</small>
Additional saving account <input checked="" type="radio"/> Yes <input type="radio"/> No	Additional Saving amount (\$) * <input type="text" value="\$ 117,000.00"/>		
	<input type="button" value="Select files..."/> ✓ Done TEST - F... x <small>File(s) upload</small>	<input type="button" value="Select files..."/> ✓ Done TEST - F... x <small>File(s) upload</small>	<input type="button" value="Select files..."/> ✓ Done TEST - F... x <small>File(s) upload</small>
Checking Amount (\$) * <input type="text" value="\$ 200,000.00"/>	<input type="button" value="Select files..."/> ✓ Done TEST - F... x <small>File(s) upload</small>	<input type="button" value="Select files..."/> ✓ Done TEST - F... x <small>File(s) upload</small>	<input type="button" value="Select files..."/> ✓ Done TEST - F... x <small>File(s) upload</small>

- 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.

Additional checking account

☒ Yes
☐ No

Please upload entire bank statement (1) *

Select files...

✓ Done

TEST - F...
File(s) upload

Please upload entire bank statement (2) *

Select files...

✓ Done

TEST - F...
File(s) upload

Please upload entire bank statement (3) *

Select files...

✓ Done

TEST - F...
File(s) upload

Additional Checking Amount (\$) *

\$ 120,000.00

Please upload most recent Stock/Bonds Quarterly statement(s) *

Select files...

✓ Done

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

Stocks/Bonds (\$)

\$ 197,000.00

Please upload most recent Other Assets Quarterly statement(s) *

Select files...

✓ Done

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

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

\$ 250,000.00

Please upload entire bank statement (1) *

Select files...

✓ Done

TEST - F...
File(s) upload

Please upload entire bank statement (2) *

Select files...

✓ Done

TEST - F...
File(s) upload

Please upload entire bank statement (3) *

Select files...

✓ Done

TEST - F...
File(s) upload

Do you receive Direct Express? *

☒ Yes
☐ No

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

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

<p>Type(s) of Property *</p> <p>Apartment Building</p>	<p>Address of Property</p> <p>New Jersey, United States</p>
<p>Type(s) of Property</p> <p>House</p>	<p>Address of Property</p> <p>New Jersey, United States</p>
<p>Type(s) of Property</p> <p>Parking Lot</p>	<p>Address of Property</p> <p>New Jersey, United States</p>

Health Insurance Information

Health Insurance Information

Do you have health insurance? *

☐ Yes
☐ No

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.

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 *

HealthCo

Private Policy Number *

T1234G565

Medicare Part A Date Eligible *

08/08/2025

Medicare Part B Date Eligible

08/08/2025

Medicare Part C Date Eligible

09/01/2025

Medicare Part D Date Eligible

09/01/2025

Medicaid Managed Care Organization (MCO) Name

Managed Care

Medicaid Managed Care Organization (MCO) Policy Number *

T45433V987

Dental Policy Name *

Delta

Dental Policy Number *

D8393454

Vision Policy Name *

DavisVision

Vision Policy Number *

56489846454

Other, please explain *

Travel 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)?

☒ --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.

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 AUTHORIZATION 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.

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 *

Jane Doe

08/08/2025

Signature

x Jane Doe

Jane Doe

Type Draw Upload Clear

(Your) Healthcare Provider Details

(Your) Healthcare Provider Details

<p>Healthcare Provider Name *</p> <input style="width: 90%;" type="text"/>	<p>Healthcare Provider Phone *</p> <input style="width: 90%;" type="text"/> <p style="color: red; font-size: small;">Healthcare Provider's Phone Number must be different than your personal Phone Number</p>
<p>Healthcare Provider Email (Please do not enter your personal email) *</p> <input style="width: 90%;" type="text"/> <p style="color: red; font-size: small;">Healthcare Provider's emails must be different than your personal email.</p>	<p>Confirm Healthcare Provider Email *</p> <input style="width: 90%;" type="text"/>

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.

1. Enter the required information.

(Your) Healthcare Provider Details

<p>Healthcare Provider Name *</p> <input style="width: 90%;" type="text" value="John Smith"/>	<p>Healthcare Provider Phone *</p> <input style="width: 90%;" type="text" value="(201) 464-7279"/>
<p>Healthcare Provider Email (Please do not enter your personal email) *</p> <input style="width: 90%;" type="text" value="john.smith@gmail.com"/>	<p>Confirm Healthcare Provider Email *</p> <input style="width: 90%;" type="text" value="john.smith@gmail.com"/>

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.

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

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

File(s) uploaded successfully.

×


2025.09.V3.1

Submit

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.



Traumatic Brain Injury Fund Application

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 HUMAN SERVICES

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

<p>Year most recent TBI occurred (yyyy) *</p> <input type="text" value="2024"/>	<p>Date TBI occurred (mm/dd)</p> <input type="text" value="12/27"/>	<p>Cause of TBI *</p> <input type="text" value="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.



Traumatic Brain Injury Fund Application

15-day Reminder Notification to Requester



Hello Jane Doe,

The TBI Fund has not received the required medical documentation 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

Please do not respond directly to this e-mail. The originating e-mail account is not monitored.

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