

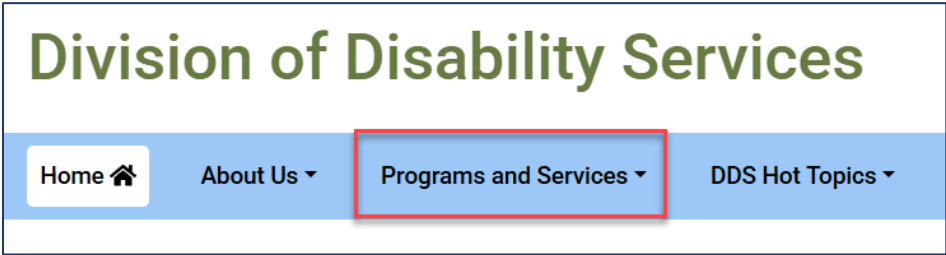
TBI Fund Vendor Application Form Quick Start Guide

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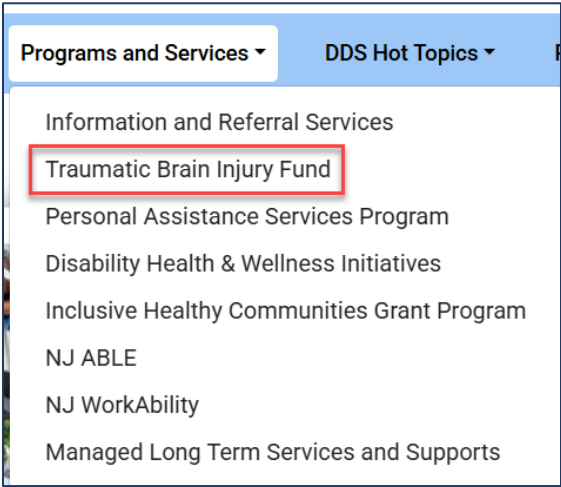
Navigating to the TBI Vendor Application Form

The TBI Vendor Application Form enables providers to submit required information, credentials, and documentation for consideration as approved vendors to the Traumatic Brain Injury Fund. To access the TBI Vendor Application Form, navigate to the Division of Disability Services website and follow the menu options to reach the Vendor Application page.

- 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**.



TBI Fund Vendor Application Form Quick Start Guide

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

Traumatic Brain Injury Fund

[DDS Home](#) [TBIF Home](#) [For Applicants](#) [For Providers](#) [Resources](#) [Meetings](#)



Traumatic Brain Injury Fund

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

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

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

A TBI is defined as an injury to the brain caused by a blow or jolt to the head or a penetrating head injury/neuro-trauma that disrupts the normal brain function, where continued impairment can be demonstrated. This definition **does not** include dysfunction caused by congenital or degenerative disorders, birth trauma, acquired brain injuries (stroke, aneurysm, etc.) or injuries caused by other circumstances.

Highlighted Resources



For Applicants
[LEARN MORE >](#)



For Providers
[LEARN MORE >](#)



Resources
[LEARN MORE >](#)



Meetings
[LEARN MORE >](#)

[Back to top](#)

TBI Fund Vendor Application Form Quick Start Guide

5. Select **Learn More**.

For Providers



How to become a TBI Fund service provider

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

Learn More

6. Select **Vendor Application**.

How to become a TBI Fund service provider

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

Vendor Application

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

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

Related Links

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

TBI Fund Vendor Application Form Quick Start Guide

The following form is displayed:



TBI FUND VENDOR APPLICATION FORM



INSTRUCTIONS: Complete the underlying form below and sign it to be considered for providing services to the Traumatic Brain Injury Fund. All required fields must be completed before the form can be submitted. Once your completed form is received, it will be reviewed and you will be notified if you have been administered a vendor interview. You may contact the TBI Fund at 1-800-205-3036, prompt #1 for questions or assistance completing the form.

Service/supplies requested prior to the receipt of formal approval and COOP letter shall be **ineligible for reimbursement**.

Items in * are required fields.

Vendor Information

Vendor Legal Name *

DOB (if applicable)

NY DUNS # *

Vendor Address *

Unit/Suite/Floor Number

Primary Contact Name *

Email *

Phone Number *

☐ Check Here Filing a third-party billing service

Upload Insurance *

Upload Insurance *

Participating Insurance Companies (Check all that apply) *

☐ Anthem

☐ Cigna Healthcare

☐ United Health Insurance (P&H)

☐ Medallion/Family Care

☐ Cigna Behavioral Health

☐ United Healthcare Insurance Company

☐ Aetna

☐ Cigna Health Plan

☐ Veterans Administration Community Care Network (VACCN)

☐ Ambetter from Workcare of New Jersey

☐ Humana

☐ Veterans Choice Program

☐ AmeriHealth HMO, Inc. and AmeriHealth HMO, CO.

☐ Kaiser Blue Cross Blue Shield of NJ

☐ Other

☐ Blue Cross Blue Shield

☐ Oscar

☐ Other

Owner Information

Owner Name *

Owner Date Of Birth *

Title held *

Owner Address *

Ownership Interest *

☒ Additional Owners

REMOVE ADDITIONAL OWNERS

1. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agents, administrators, employees or managing employees been arrested, charged, indicted or convicted in a criminal or delinquent persons matter by the State of New Jersey, any other state or the U.S. Government? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

2. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agents, administrators, employees or managing employees been suspended, delinquent or otherwise declared ineligible by any Local, State or Federal Government agency from bidding or contracting to provide services, labor, material or support? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

3. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agents, administrators, employees or managing employees currently involved with a pending criminal matter or delinquent proceeding? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

4. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agents, administrators, employees or managing employees been the subject of any past or pending license suspension, revocation, or other adverse action by any licensing authority, including but not limited to any fire, jewelry, cosmetology, disciplinary action or probationary period (even if paid and/or resolved) imposed by any licensing authority (including motor vehicle violations), in this state or any other jurisdiction? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

5. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agents, administrators, employees or managing employees been the subject of any past or pending licensure, delinquency, or other adverse action or criminal conviction involving Medicaid, Medicare or any other federally funded or state-funded health care program, any private or non-profit health insurance plan or program in this state or any other jurisdiction, or any other program administered in whole or in part by DHS? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

6. CERTIFICATION: I hereby represent and state that the foregoing information and any attachments thereto to the best of my knowledge are true and complete. I acknowledge that I am under a continuing obligation from the date of this certification to notify the State in writing of any changes to the answers or information contained herein. I am aware that any of the foregoing statements made by me is a willful false, false or subject punishment. *

Service Information

Number of proposed services provided by vendor *

Select one *

Supporting Documents

Upload Supporting Documents (Optional)

Upload File

Vendor Declaration

☐ I hereby declare and agree to the following: (1) To ensure that all required licenses, certifications, and accreditations remain current at all times; (2) To ensure that all applicable staff maintain current New Jersey licenses, certifications, or other regulatory credentials required by their profession prior to rendering any service; (3) To render only those services for which I am authorized, and only in accordance with the frequency, scope, duration, and effective and termination dates approved by the TBI Fund; (4) Not to subcontract any services that I have committed to provide under this application; (5) To maintain all records necessary to fully reflect the extent of services provided to individuals receiving assistance paid for by the TBI Fund, and to provide any authorized DDS employee or agent with copies of requested records free of all copy fees or duplication charges; (6) To comply with all applicable state and federal laws, regulations, and administrative procedures; (7) To make available to the Division and/or its agents any records deemed necessary by DDS to verify that services are being properly rendered. *

I certify that the information provided in this vendor application is true and correct to the best of my knowledge, and that I agree to comply with the terms and conditions as per NJAC 10:14. I understand that I must disclose the names of all other sources for which payment was requested, denied or received for any claim submitted to the TBI Fund. Such sources include but are not limited to Medicaid, Medicare, Veterans' Compensation or any other private or public insurance or payer. *

I understand that upon submission of this application form including all documents, it becomes property of the State of New Jersey. The enrollment packet and any documents that are generated as a result of the submission of this application, such as but not limited to, an enrollment letter or a denial letter are submitted to the State Public Records Act (CPRA), see NJA Section 17:27, before any documents are provided pursuant to a CPRA request. All personal information such as name and social security number will be redacted. It is the responsibility of the person signing this to ensure this information is all of individuals who are named in this application. I have read this agreement of Understanding and acknowledge that once I submit these documents for processing that they will become property of the State of New Jersey. *

Name *

Date *

Vendor Signature *

Signer's Name

Type

Draw

Upload

Clear

10/10/2020

Clear

Submit

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TBI Fund Vendor Application Form Quick Start Guide

Vendor Information

The Vendor Information section records basic information required from the vendor.

Vendor Information

Vendor Legal Name *

DBA (if applicable)

NJ START # *

Vendor Address *

Unit/Suite/POBox Number

Primary Contact Name *

Email *

Phone Number *

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

Upload Resume(s) *

Upload Insurance *

Participating Insurance Companies (Check all that apply) *

☐ Medicare
☐ Medicaid/NJ Family Care
☐ Aetna
☐ Ambetter from WellCare of New Jersey
☐ AmeriHealth HMO Inc. and AmeriHealth Ins. Co.
☐ Blue Cross Blue Shield

☐ Cigna Healthcare
☐ Cigna Behavioral Health
☐ Clover Health Plan
☐ Humana
☐ Horizon Blue Cross Blue Shield of NJ
☐ Oscar

☐ Oxford Health Insurance (NJ) Inc.
☐ United Healthcare Insurance Company
☐ Veteran's Administration Community Care Network (VACCN)
☐ Veterans Choice Program
☐ Other

1. Enter the required information.

Vendor Information

Vendor Legal Name *

DBA (if applicable)

NJ START # *

Vendor Address *

Unit/Suite/POBox Number

TBI Fund Vendor Application Form Quick Start Guide

- 2. Enter the required information.
- 3. If relevant, select the **Check here if using a third-party billing service:** box.

Primary Contact Name *

Email *

Phone Number *

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

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

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

Name of Billing Service *

Billing Contact Name *

Billing Email *

Billing Phone Number *

- 4. Upload the required files.

Upload Resume(s) *

Upload Insurance *

Select files...

Select files...

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

Participating Insurance Companies (Check all that apply) *

☐ Medicare

☐ Cigna Healthcare

☐ Oxford Health Insurance (NJ) Inc.

☐ Medicaid/NJ Family Care

☐ Cigna Behavioral Health

☐ United Healthcare Insurance Company

☐ Aetna

☐ Clover Health Plan

☐ Veteran's Administration Community Care Network (VACCN)

☐ Ambetter from WellCare of New Jersey

☐ Humana

☐ Veterans Choice Program

☐ AmeriHealth HMO Inc. and AmeriHealth Ins. Co.

☐ Horizon Blue Cross Blue Shield of NJ

☐ Other

☐ Blue Cross Blue Shield

☐ Oscar

Note: An additional field is displayed if Other is selected.

☐ AmeriHealth HMO Inc. and AmeriHealth Ins. Co.

☐ Horizon Blue Cross Blue Shield of NJ

☒ Other

☐ Blue Cross Blue Shield

☐ Oscar

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

TBI Fund Vendor Application Form Quick Start Guide

Owner Information

The Owner Information section records key details about the owner.

Owner Information

Owner Name *

Owner Date Of Birth *

MM/dd/yyyy

Title Held *

Owner Address *

Ownership Interest *

(Shares Owned or % of Partnership)

Additional Owners

+ ADD ADDITIONAL OWNERS

REMOVE ADDITIONAL OWNERS

1. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees ever been arrested, charged, indicted or convicted in a criminal or disorderly persons matter by the State of New Jersey, any other state or the U.S. Government? (If yes, attach a detailed explanation for each instance.) *

Yes

No

2. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees ever been suspended, debarred or otherwise declared ineligible by any Local, State or Federal government agency from bidding or contracting to provide services, labor, material or supplies? (If yes, attach a detailed explanation for each instance.) *

Yes

No

3. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees currently involved with a pending criminal matter or debarment proceeding? (If yes, attach a detailed explanation for each instance.) *

Yes

No

4. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees ever been the subject of any past or pending license suspension, revocation, or other adverse action by any licensing authority, including but not limited to any fine, penalty, reprimand, disciplinary action or probationary period (even if paid and/or resolved) imposed by any licensing authority (excluding motor vehicle violations), in this state or any other jurisdiction? (If yes, attach a detailed explanation for each instance.) *

Yes

No

5. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees ever been the subject of any past or pending suspensions, debarments, disqualifications, recovery action or criminal convictions involving Medicaid, Medicare or any other federally-funded or state-funded health care program, any private or non-profit health insurance plan or program in this state or any other jurisdiction, or any other programs administered in whole or in part by DHS? (If yes, attach a detailed explanation for each instance.) *

Yes

No

CERTIFICATION: I hereby represent and state that the foregoing information and any attachments thereto to the best of my knowledge are true and complete. I acknowledge that I am under a continuing obligation from the date of this certification to notify the State in writing of any changes to the answers or information contained herein. I am aware that if any of the foregoing statements made by me is willfully false, I may be subject to punishment. *

1. Enter the required information.

Owner Name *

Owner Date Of Birth *

MM/dd/yyyy

Title Held *

Owner Address *

Ownership Interest *

(Shares Owned or % of Partnership)

Additional Owners

+ ADD ADDITIONAL OWNERS

REMOVE ADDITIONAL OWNERS

TBI Fund Vendor Application Form Quick Start Guide

Note: Select ‘ADD ADDITIONAL OWNERS’ to enter information for any additional owners associated with the vendor. Select REMOVE ADDITIONAL OWNERS to delete an added entry, or select the trash bin icon to remove a specific owner.

☒ Additional Owners

Owner Name *

Owner Date Of Birth *

MM/dd/yyyy

Title Held *

Owner Address *

Ownership Interest *

(Shares Owned or % of Partnership)

ADD ADDITIONAL OWNERS

REMOVE ADDITIONAL OWNERS

2. Select **Yes** or **No**.

Note: If yes, attach a detailed explanation for each instance.

1. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees ever been arrested, charged, indicted or convicted in a criminal or disorderly persons matter by the State of New Jersey, any other state or the U.S. Government? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

2. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees ever been suspended, debarred or otherwise declared ineligible by any Local, State or Federal government agency from bidding or contracting to provide services, labor, material or supplies? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

3. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees currently involved with a pending criminal matter or debarment proceeding? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

3. Select **Yes** or **No**.

Note: If yes, attach a detailed explanation for each instance.

4. Select the **CERTIFICATION** box.

4. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees ever been the subject of any past or pending license suspension, revocation, or other adverse action by any licensing authority, including but not limited to any fine, penalty, reprimand, disciplinary action or probationary period (even if paid and/or resolved) imposed by any licensing authority (excluding motor vehicle violations), in this state or any other jurisdiction? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

5. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees ever been the subject of any past or pending suspensions, debarments, disqualifications, recovery action or criminal convictions involving Medicaid, Medicare or any other federally-funded or state-funded health care program, any private or non-profit health insurance plan or program in this state or any other jurisdiction, or any other programs administered in whole or in part by DHS? (If yes, attach a detailed explanation for each instance.) *

☐ Yes

☐ No

☐ CERTIFICATION: I hereby represent and state that the foregoing information and any attachments thereto to the best of my knowledge are true and complete. I acknowledge that I am under a continuing obligation from the date of this certification to notify the State in writing of any changes to the answers or information contained herein. I am aware that if any of the foregoing statements made by me is willfully false, I may be subject punishment. *

TBI Fund Vendor Application Form Quick Start Guide

Services Information

The Services Information section collects details on the services the vendor intends to provide and any required licenses or certifications.

Service Information

Number of proposed services provided by vendor *

-- Select one --

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

Service Information

Number of proposed services provided by vendor *

-- Select one --

-- Select one --

1

2

3

4

5

TBI Fund Vendor Application Form Quick Start Guide

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

Service Information

Number of proposed services provided by vendor *

2

Service 1

Service Name-1 *

CPT Code *

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

Service Description *

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

Rate (Total amount per session or item) *

Unit (i.e., per item, 30 or 60 min session) *

\$

\$

Service 2

Service Name-2 *

CPT Code *

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

Service Description *

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

Rate (Total amount per session or item) *

Unit (i.e., per item, 30 or 60 min session) *

\$

\$

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TBI Fund Vendor Application Form Quick Start Guide

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

Service Name-1

CPT Code *

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

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

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

Licensing Body *

Credential # *

Active Date (From)

Active Date (To)

Upload License(s)/Certificate(s) (If Applicable) *

- 4. Enter the required information.

Service Description *

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

Rate (Total amount per session or item) *

Unit (i.e., per item, 30 or 60 min session) *

TBI Fund Vendor Application Form Quick Start Guide

Supporting Documents

The Supporting Documents section allows vendors to upload any files needed to support their application

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

Supporting Documents

Upload Supporting Documents (Optional)

Select files...

Note: When a file is successfully uploaded, it appears below the upload button with the file name, a green confirmation message, and an option to remove the file if needed.

Supporting Documents

Upload Supporting Documents (Optional)

Select files...

✓ Done

 TEST - For attachments in forms.docx 

File(s) uploaded successfully.

TBI Fund Vendor Application Form Quick Start Guide

Vendor Declaration

The Vendor Declaration section requires the vendor to certify the information provided, enter their name, and complete the required signature.

Vendor Declaration

☐ I hereby declare and agree to the following: (1) To ensure that all required licenses, certifications, and accreditations remain current at all times. (2) To ensure that all applicable staff maintain current New Jersey licenses, certifications, or other regulatory credentials required by their profession prior to rendering any service. (3) To render only those services for which I am authorized, and only in accordance with the frequency, scope, duration, and effective and termination dates approved by the TBI Fund. (4) Not to subcontract any services that I have committed to provide under this application. (5) To maintain all records necessary to fully disclose the extent of services provided to individuals receiving assistance paid for by the TBI Fund, and to provide any authorized DDS employee or agent with copies of requested records free of all copy fees or duplication charges. (6) To comply with all applicable state and federal laws, regulations, and administrative procedures. (7) To make available to the Division and/or its agents any records deemed necessary by DDS to verify that services are being properly rendered. *

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

☐ I understand that upon submission of this application form including all documents, it becomes property of the State of New Jersey. The enrollment packet and any documents that are generated as result of the submission of this application, such as but not limited to, an enrollment letter or a denial letter are subjected to the Open Public Records Act (OPRA, see N.J.S.A. Section 47:1A). Before any documents are provided pursuant to an OPRA request, all personal information such as tax id and social security numbers will be redacted. It is the responsibility of the person signing this to convey this information to all of individuals who are named in this application. I have read this Agreement of Understanding and acknowledge that once I submit these documents for processing that they will become property of the State of New Jersey. *

Name *

Date *

09/11/2026

Vendor Signature *

✕

Signer's Name

Type Draw Upload Clear

2026.09.V1.3

Clear

Submit

1. Select the required certification boxes to confirm the accuracy of the information before entering your name and signature.

☐ I hereby declare and agree to the following: (1) To ensure that all required licenses, certifications, and accreditations remain current at all times. (2) To ensure that all applicable staff maintain current New Jersey licenses, certifications, or other regulatory credentials required by their profession prior to rendering any service. (3) To render only those services for which I am authorized, and only in accordance with the frequency, scope, duration, and effective and termination dates approved by the TBI Fund. (4) Not to subcontract any services that I have committed to provide under this application. (5) To maintain all records necessary to fully disclose the extent of services provided to individuals receiving assistance paid for by the TBI Fund, and to provide any authorized DDS employee or agent with copies of requested records free of all copy fees or duplication charges. (6) To comply with all applicable state and federal laws, regulations, and administrative procedures. (7) To make available to the Division and/or its agents any records deemed necessary by DDS to verify that services are being properly rendered. *

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

☐ I understand that upon submission of this application form including all documents, it becomes property of the State of New Jersey. The enrollment packet and any documents that are generated as result of the submission of this application, such as but not limited to, an enrollment letter or a denial letter are subjected to the Open Public Records Act (OPRA, see N.J.S.A. Section 47:1A). Before any documents are provided pursuant to an OPRA request, all personal information such as tax id and social security numbers will be redacted. It is the responsibility of the person signing this to convey this information to all of individuals who are named in this application. I have read this Agreement of Understanding and acknowledge that once I submit these documents for processing that they will become property of the State of New Jersey. *

TBI Fund Vendor Application Form Quick Start Guide

- 2. Enter the vendor **Name**.
- 3. **Type, Draw, or Upload** the **Vendor Signature**.

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

- 4. Select **Submit**.

Name *

Date *

09/15/2026

Vendor Signature *

×

Signer's Name

Type Draw Upload **Clear**

2026.09.V1.3

Clear

Submit

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



TBI FUND VENDOR APPLICATION FORM



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

TBI Fund Vendor Application Form Quick Start Guide

Email Notifications

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

Submission Confirmation Email Notification

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



Traumatic Brain Injury Vendor Application

Submission Confirmation

Dear Jane Doe,

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

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

ACTION REQUIRED: None.

If you have any questions, please contact the NJ TBI Fund at DDS-TBI.VendorApplications@dhs.nj.gov 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.

TBI Fund Vendor Application Form Quick Start Guide

Request for Additional Information

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

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

Request for Additional Information by the TBI Analyst

The ‘Request for Additional Information by the TBI Analyst’ notification informs the vendor that the analyst requires further details and directs them to review the highlighted service comments and submit the necessary updates.

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



Traumatic Brain Injury Vendor Application

Request for Additional information



Dear Jane Doe,

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

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

Please find Vendor’s information below:

Vendor Legal Name: Jane Doe

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

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

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

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

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TBI Fund Vendor Application Form Quick Start Guide

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

Service Information

Number of proposed services provided by vendor

2

Service 1

Service Name-1

CPT Code *

Test 1

97110

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

Service Description *

Therapeutic Exercise

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

Rate (Total amount per session or item) *

Unit (i.e., per item, 30 or 60 min session) *

\$ 100.00

30

TBI Analyst Decision for Service-1:

Reviewed

Service 2

Service Name-2

CPT Code *

Test 2

97140

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

Service Description *

Therapy

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

Rate (Total amount per session or item) *

Unit (i.e., per item, 30 or 60 min session) *

\$ 90.00

60

Action Required: Please review comments by TBI Fund Staff

TBI Analyst Decision for Service-2:

Comments from TBI Analyst for Service-2:

Require Additional Information

Please add more details.

TBI Fund Vendor Application Form Quick Start Guide

Request for Additional Information by the TBI Supervisor

The 'Request for Additional Information by the TBI Supervisor' notification informs the vendor that the supervisor requires further clarification and directs them to review the highlighted service comments and submit the necessary updates.

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



Traumatic Brain Injury Vendor Application
Request for Additional information



Dear Jane Doe,

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

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

Please find Vendor's information below:

Vendor Legal Name: Jane Doe

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

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

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

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TBI Fund Vendor Application Form Quick Start Guide

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

Service Information

Number of proposed services provided by vendor

2

Service 1

Service Name-1

CPT Code *

Test 1

97110

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

Service Description *

Therapeutic Exercise

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

Rate (Total amount per session or item) *

Unit (i.e., per item, 30 or 60 min session) *

\$ 100.00

30

Action Required: Please review comments by TBI Fund Staff

TBI Analyst Decision for Service-1

Reviewed

Comments from TBI Analyst for Service-1

Reviewed. Waiting for next approval.

TBI Supervisor Decision for Service-1

Require Additional Information

Comments from TBI Supervisor for Service-1

Require Following Additional Information:

Service 2

Service Name-2

CPT Code *

Test 2

97140

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

Service Description *

Therapy

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

Rate (Total amount per session or item) *

Unit (i.e., per item, 30 or 60 min session) *

\$ 90.00

60

TBI Analyst Decision for Service-2

Reviewed

Comments from TBI Analyst for Service-2

Reviewed. Waiting for next approval.

TBI Supervisor Decision for Service-2

Approved

Comments from TBI Supervisor for Service-2

Approved

TBI Fund Vendor Application Form Quick Start Guide

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



Traumatic Brain Injury Vendor Application

Submission Confirmation

Dear Jane Doe,

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

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

ACTION REQUIRED: None.

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

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TBI Fund Vendor Application Form Quick Start Guide

Canceled Email Notification

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



Traumatic Brain Injury Vendor Application
TBI Vendor Application Canceled



Dear Jane Doe,

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

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

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

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TBI Fund Vendor Application Form Quick Start Guide

Application Approved/Partially Approved

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

 TBI VAPP Application-Complete.pdf
112 KB



Traumatic Brain Injury Vendor Application

TBI Vendor Application Approved/Partially Approved

Hello Jane Doe,

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

ACTION REQUIRED: None

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

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TBI Fund Vendor Application Form Quick Start Guide

Rejected Email Notification

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

 TBI VAPP Application-Reserved.pdf
109 KB



Traumatic Brain Injury Vendor Application
TBI Vendor Application Rejected



Hello Jane Doe,

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

ACTION REQUIRED: None

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

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