State Council for Persons with Disabilities (SCPD)

APPLICATION FOR BRAIN INJURY FUND ASSISTANCE

APPLICANT CONTACT INFORMATION

Name:

Telephone:	Street Address:	
Mailing Address *(if different)*:		
Email Address:		
City:	State:	ZIP Code:

AUTHORIZED REPRESENTATIVE

I (Your name) want (Your Representative's Name) to be my representative for the purpose of application and case review only. ☐ Yes ☐ No

I (Representative's Name) am the representative for (Applicant's Name) for application.
☐ Yes ☐ No Representative's Email Address:

DEMOGRAPHIC & FINANCIAL INFORMATION

Date of Birth: Gender: ☐ Male ☐ Female

Race / Ethnicity:
☐ American Indian/Alaskan Native ☐ Black/African American ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ Caucasian ☐ Hispanic/Latino
☐ Non-Hispanic/Latino

Individual's Income Source and Amount (E.g., wages, unemployment, SSI):

Individual's Total Liquid Resources (E.g., Savings; Stocks or bonds; Cash on Hand):

HEALTH INSURANCE INFORMATION

[Including Medicare, Medicaid, Delaware Health Children's Program (CHIP)]

Name of Policy Holder	Name of Insurance	Who is Covered?	Policy Number

SOURCE OF REFERRAL

How did you find out about the program?

ELIGIBILITY

Delaware Resident: ☐ Yes ☐ No	Date of Brain Injury:	Brain Injury Diagnosis & Source/Documentation *(Submit to SCPDBrainInjuryFund@state.de.us)*:

Desired Services (check all that apply): ☐ Home Modifications ☐ Environmental Modifications

☐ Driver Rehabilitation
☐ Assistive Technology
☐ Other Services – Specify
☐ Estimated Cost if Known:
☐ Service Dog Acquisition & Support
☐ Attendant Services

Availability of Services through Delaware Department of Health & Social Services (DHSS):

a. Are you currently on a waiting list for a DHSS program which includes a covered service? ☐ Yes ☐ No
b. Are you currently enrolled in a DHSS program but would benefit from a type of support service not offered in the program? ☐ Yes ☐ No
c. Have you been told that you do not meet the technical eligibility standards for a DHSS program which includes a covered service resulting in individual or family hardship? ◯ Yes ◯ No, If yes, what was the reason?
d. Have you submitted an application for a DHSS program? If so, are you waiting to hear back from the Department? ☐ Yes ☐ No ◯ Yes ◯ No
e. Do you have a DHSS case manager? ◯ Yes ◯ No If so, who is it? What is her/his contact information?
f. Have you looked for other programs, community resources, churches or charities that may fund the desired service/s? ◯ Yes ◯ No, If so, what are they and what was the response?

ACKNOWLEDGEMENT & SIGNATURE

I understand that the Brain Injury Fund is a limited pilot program, that services are subject to modest funds approved in the State budget, and that I will receive a written decision from the SCPD in response to the application. I further understand and agree that approval of this application, in whole or in part, does not bind the State or its agents to provide services of a type, frequency, or duration outside the scope of the written decision. Since the State Council is required to prepare a report on the impact of services provided under this pilot program, I agree to participate in interview(s) to discuss the benefits of such services. Finally, I understand that the SCPD may need to consult other public and private agencies and potential service providers to process and fulfill this application. I agree that information and records may be freely exchanged among the SCPD and such agencies and providers without the need for further authorization. ☐

AGREEMENT: ☐ By signing this Electronic Signature Acknowledgment Form, **I agree that my electronic signature is the legally binding equivalent to my handwritten signature.** Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding. I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.

Signature of Applicant:	Date:
Signature of Representative:	Date:

After completing all required fields, electronically signing and attaching required documentation to this application, please select the "SUBMIT" button to return this document to SCPD. Applications are accepted electronically (preferred), in-person at the SCPD Office, through the U. S. Mail, or by email to: SCPDBrainInjuryFund@state.de.us . Contact information for SCPD is: *State Council for Persons with Disabilities, Margaret O'Neill Building, Third Floor, Suite 1, 410 Federal Street, Dover, DE 19901. Phone: (302) 739-3620,* Email: SCPDGeneralMailbox@state.de.us

Attach Documents **Print** **SUBMIT Application**