Brain Injury Fund Application Instructions

Hover your mouse cursor over each text box, checkbox, or radio button to read instructions and examples on the information required to complete the application. The pop-up will also let you know if the field is required or whether you can enter N/A if not applicable to the applicant.

APPLICANT CONTACT INFORMATION

- Begin by entering the **applicant's full legal name**.
- Enter the **applicant's telephone number** including area code and dashes. E.g. **302-123-1234**
- Enter the **applicant's street address** including development name where applicable.
- Enter **applicant's mailing address** if different than applicant's street address. **E.g. P. O. Box numbers, Apartment Complex name and apartment number.**
- Enter **applicant's email address**.
- Enter the **city where the applicant resides**. Enter the **state where the applicant resides**.
- Enter the **Zip-code plus 4**. If plus 4 is not known, enter 4 zeros to be able to continue on to the next section of the document. **E.g. 19901-0000**

AUTHORIZED REPRESENTATIVE

- Enter **applicant's name** AND **representative's name** if applicant wants someone to represent them solely for the purpose of this application and case review.
- Re-enter **representative's name** and **applicant's name** for representative to confirm that they agree to represent the applicant.
- Enter **representative's email address** for SCPD to contact during processing of application.

DEMOGRAPHIC & FINANCIAL INFORMATION

- Enter **applicant's date of birth** in month, month/day, day/year, year, year, year format.
- Select **applicant's gender**.
- Select **applicant's race/ethnicity**.
- Enter **applicant's income sources** and amount including wages, unemployment, SSI, Disability, Pension, etc.
- Enter **applicant's total liquid resources** including cash on hand, checking, savings, Certificate of Deposits, stocks and bonds owned.

HEALTH INSURANCE INFORMATION

- List **all** health insurance information covering the applicant including Medicare, Medicaid, Employer health insurance, Tricare, Tricare For Life including name of policy holder, Insurance name, who is covered e.g. applicant, spouse, children, and the insurance policy number. If you list Medicaid or Delaware Health Children's Program insurance please answer "Yes" to question "b." on the next page.

SOURCE OF REFERRAL

- Please provide the name of the person, committee, organization, or website that told you about the Brain Injury Fund Assistance Program.

ELIGIBILITY

- Please select either yes or no to signify if the applicant is a Delaware Resident.
- Please enter the **date of the applicant's brain injury** (or diagnosis of brain injury) occurred in month, month/day, day/year, year, year, year format.
- Please list the **type of documents** that you are attaching for submission with your application. E.g. Brain Injury Diagnosis medical records, rehab records, and other treatment/diagnosis documentation.

DESIRED SERVICES

- Please **select** all **services** that the **applicant is requesting** assistance in obtaining. Please specify services if selecting "Other Services". Enter estimated cost if known. E.g. Vendor or State Agency Quote or estimate of cost of services. (If available, please attach a copy.)

AVAILABILITY OF SERVICES THROUGH DELAWARE DEPARTMENT OF HEALTH & SOCIAL SERVICES (DHSS)

- **Select yes or no** to let us know if the applicant is currently on a waiting list for a DHSS program that would include a service that the applicant is requesting.
- **Select yes or no** to let us know if the applicant is currently enrolled in a DHSS program but are requesting services or assistance with something not offered through that program.
- **Select yes or no** to let us know if the applicant (or the applicant's representative) was ever told that he/she did not meet technical eligibility standards for a DHSS program that covers a service requested. If responding yes, please enter the reason provided for the ineligibility.

- **Select yes or no** to let us know if the applicant (or someone on their behalf) submitted an application for a DHSS program. If responding yes, please select yes or no to respond to whether or not you are still waiting to hear back from DHSS.
- **Select either yes or no** to let us know if the applicant has a DHSS case manager. If responding yes, please list the case manager's name. If yes, please also provide the case manager's phone and email address.
- **Select yes or no** to let us know if the applicant (or someone on the applicant's behalf) looked for other programs, community resources, churches, or charity services, assistance, and/or funding. If responding yes, please list the program, resource, church, or charity and the response to the request.

ACKNOWLEDGEMENT & SIGNATURE

- The applicant and representative (if any) should read (or have read to them) the **Acknowledgement Statement and Authorization** and select the checkbox to signify that the applicant and representative read and agree to the statement.
- The applicant and representative (if any) should read (or have read to them) the **Electronic Signature Agreement** and **Authorization** and select the checkbox to signify that the applicant and representative read and agree to the statement.
- The applicant and representative (if any) should enter their electronic signature and date of signature on the designated lines if submitting the application electronically.
- If the application is being submitted through U. S. Mail or in person both the applicant and the representative may manually sign the document in the spaces provided.

Final Action Buttons

- Please select the "**Attach Documents**" button once for each document that you are attaching to submit with the Brain Injury Fund Application. You can verify that all of your documents attached by selecting "View" from the menu bar, then selecting "Show/Hide" from the dropdown list and following the arrow over to select "Navigation Panes" and following the arrow over once more to select "Attachments".

- Once you are satisfied that all of your source documentation attached, please select the "**Print**" button to print a copy of the completed application for your records.

- The final step in completing a Brain Injury Fund Application is selecting the black and white "**SUBMIT Application**" button located on the bottom right of the application's last page. You can add your email address in the "Cc" line if you would like an electronic copy for your records. If you prefer you may also submit your application through U.S. Mail. Please see **SAMPLE APPLICATION** below.

State Council for Persons with Disabilities (SCPD)

APPLICATION FOR BRAIN INJURY FUND ASSISTANCE

APPLICANT CONTACT INFORMATION

Name: Jane Q. Public

Telephone: (302) 123-4567 | Street Address: 100 Main Street, Kent Acres

Mailing Address *(if different)*: P. O. Box 123

Email Address: Jane.Public000@mailprovider.com

City: Dover | State: Delaware | ZIP Code: 19901-0000

AUTHORIZED REPRESENTATIVE

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

I John A. Public (Representative's Name) am the representative for Jane Q. Public (Applicant's Name) for application.

■ Yes ☐ No Representative's Email Address: JohnA.Public@mailprovider.net

DEMOGRAPHIC & FINANCIAL INFORMATION

Date of Birth: 01/01/1950 | 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):
$15,000 wages, $9,000 SSI

Individual's Total Liquid Resources (E.g., Savings; Stocks or bonds; Cash on Hand):
$ $2,500 savings account, $50.00 cash on hand, 0 stocks, and 0 bonds.

HEALTH INSURANCE INFORMATION

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

Name of Policy Holder	Name of Insurance	Who is Covered?	Policy Number
John A. Public	Highmark BC/BS DE	Jane Q. Public	SOD9876543210
Jane Q. Public	United Healthcare Insurance	Jane Public	12345678910

SOURCE OF REFERRAL

How did you find out about the program? Jane Doe, Friend

ELIGIBILITY

Delaware Resident: ■ Yes ☐ No	09/13/2016 Date of Brain Injury:	Brain Injury Diagnosis & Source/Documentation *(Submit to SCPDBrainInjuryFund@state.de.us):*

Emergency Room Records from initial injury, Rehab treatment records, Neurological Medical Records, Recent Assessment

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

- ☐ Driver Rehabilitation ☐ Service Dog Acquisition & Support
- ☑ Assistive Technology ☑ Attendant Services
- ☑ Other Services – Specify Transportation to day services and rehab.
- ☐ Estimated Cost if Known:

Unknown

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? Functioning level too high

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? Helpful Case Worker
What is her/his contact information? DHSS, Long-term Care, 302-456-7890, help@state.de.us

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?

Church Funding, ineligible due to husband's income, Easter Seals, on wait-list,

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: *Jane Q. Public*	Date: 09/13/16
Signature of Representative: *John A. Public*	Date: 09/13/16

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