

State Council for Persons with Disabilities (SCPD)  
**APPLICATION FOR BRAIN INJURY FUND ASSISTANCE**

**APPLICANT CONTACT INFORMATION**

Name:	Date of Birth:
Street Address:	City, State, ZIP Code:
Mailing Address (if different):	City, State, ZIP Code:
Email Address:	
Home phone:	Cell Phone:
How did you find out about the program? (social media, SCPD website, a doctor, etc.)	

Who is completing this application? Applicant (myself) or  
 someone else? (person's name) \_\_\_\_\_  
 If someone else is completing the form, what is their following information:

Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

**DEMOGRAPHIC INFORMATION (OPTIONAL)**

Gender:  Male  Female  Other

Are you/applicant a veteran?  Yes  No

Race / Ethnicity:

<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian
<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> Non-Hispanic/Latino	Other: _____	

**HEALTH INSURANCE INFORMATION (REQUIRED)**

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

Name of Policy Holder	Name of Insurance	Who is Covered?

**ELIGIBILITY**

<p><b>Date of Traumatic Brain Injury?</b></p>  <p><b>What caused your TBI?</b></p>	<p><b>TBI Diagnosis:</b></p>
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**Supporting Documentation:** Please attach any supporting documentation or doctor's notes that support your TBI diagnosis, current treatment and recommended services being

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requested below. Please email the supporting documentation with your application to:  
[SCPDBrainInjuryFund@delaware.gov](mailto:SCPDBrainInjuryFund@delaware.gov).

**Requested Services:** (check the services you are requesting) List specific services **requested including the estimated cost** for each item or service requested. The TBI Fund does not pay for services received prior to receipt of written approval by the Committee.

- Home or Environmental Modifications:
  
- Driver Assessment & Training (Physicians Note verifying ability to receive training **Required**):
  
- Neurofeedback Therapy (# of sessions requested):

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- Assistive Technology (Type, Brand, Make, Model):
  
- Short-term Treatment or Therapy:
  
- Other Services or Treatment – List services, treatments and specify purpose:

**Delaware Department of Health & Social Services (DHSS)**

**DHSS services include** the Division of Medicaid & Medical Assistance (DMMA), Long Term Care (LTC), Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), Division of Substance Abuse and Mental Health (DSAMH), Caregiver Support, Delaware's A Better Chance (DABC), Temporary Assistance for Needy Families (TANF), Community Resource and Assistance Services, Emergency Assistance Services and the Division for the Visually Impaired (DVI) services.

Availability of Services through Delaware **D**epartment of **H**ealth & **S**ocial **S**ervices (**DHSS**):

- a. Do you currently services through a DHSS program which includes a covered service?  
 Yes    No
- b. Are you currently on a waiting list for a DHSS program which includes a covered service?  
 Yes    No

**ACKNOWLEDGEMENT & SIGNATURE**

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**ACKNOWLEDGEMENT:** I understand that the TBI Fund has limited funds, that services are subject to funds approved in the State budget, and that I will receive a written decision from the SCPD in response to my 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 program, I agree to provide a statement of impact of how the receipt of these funds has helped me and my TBI which may be published on the SCPD website. 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 exchanged between the SCPD, such agencies and providers without the need for further authorization. Services received prior to written approval are not eligible for payment by Delaware's TBI Fund.

**SIGNATURE:** By signing this Electronic Signature Acknowledgment Form, **I agree that my electronic signature is the legally binding equivalent to my handwritten signature.** I understand that by typing my name and/or signing my signature below constitutes a legal signature confirming that I acknowledge and agree to the truthfulness of the information provided in this document and understand and agree to the acknowledgement above.

Signature of Applicant:

Date:

After completing and electronically signing this document **please save or print a copy for your records before selecting the "SUBMIT" button at the end of the document to return your fully completed application to SCPD. Applications are accepted electronically (preferred) by using the attach documents and "SUBMIT" buttons, by submitting through email to: [SCPDBrainInjuryFund@delaware.gov](mailto:SCPDBrainInjuryFund@delaware.gov), in-person at the SCPD Office, or by sending a hard copy through the U. S. Mail to our office. Contact information for SCPD is: State Council for Persons with Disabilities, TBI Fund, Margaret O'Neill Building, Third Floor, Suite 1, 410 Federal Street, Dover, DE 19901. Phone: (302) 739-3620, Email: [SCPGeneralMailbox@delaware.gov](mailto:SCPGeneralMailbox@delaware.gov)**