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 CONTACT INFORMATION

Mailing Address:

Email Address(es):

Phone: Cellphone:

Relationship to applicant:

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 Other: _____

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

How did you find out about the program?

ELIGIBILITY

Delaware Resident: ☐ Yes ☐ No **Is applicant a veteran?** (Additional services may be available for veterans.) ☐ Yes ☐ No	**Date of Traumatic Brain Injury**? **Mechanism of Injury?**	**TBI Diagnosis & Supporting Documentation**: Enter type of TBI below listing document names below before attaching documents to the application or email documents to: SCPDBrainInjuryFund@delaware.gov)

Requested Services: (check the services you are requesting) List specific services **requested <u>including the estimated cost</u>** <u>for each item or service requested:</u> Do you ☐ own or ☐ rent your home? **If rented**, please supply landlord's contact information:

Name: _____ Phone: _____ Email:_____

☐ Home or Environmental Modifications (Estimates required from State Approved Vendor):

☐ Driver Assessment & Training (Physicians Note verifying ability to receive training **Required**):

☐ Neurofeedback Therapy (# of sessions requested):

☐ Assistive Technology (Type, Brand, Make, Model):

☐ Short-term Treatment or Therapy:

☐ Other Services or Treatment – List services, treatments and specify purpose:

☒Estimated Cost for each item requested above. (**Required**):

Delaware <u>D</u>epartment of <u>H</u>ealth & <u>S</u>ocial <u>S</u>ervices (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. 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 **If yes, please list the type of support service**?

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? ☐ Yes ☐ No
If yes, are you waiting to hear back from the Department? ☐ Yes ☐ No

e. Do you have a **DHSS case manager**? ☐ Yes ☐ No
If yes, **what is their name**?
What is your case manager's **phone number**?
What is your case manager's **email address**?

f. Have you looked for other programs, community resources, churches or charities that may fund the desired service(s)? ☐ Yes ☐ No. If yes, please list who they are and what was the response?

ACKNOWLEDGEMENT & SIGNATURE

ACKNOWLEDGEMENT: I understand that the TBI Fund is a limited fund 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 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 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 exchanged between the SCPD, such agencies and providers without the need for further authorization.

SIGNATURE: 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 by typing my name and/or affixing my signature below constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document and understand and agree to the acknowledgement above.

Signature of Applicant:	Date:
Signature of Representative:	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, 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: SCPDGeneralMailbox@delaware.gov

Attach Documents | Print Application | Submit Application