Traumatic 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 whether they agree to represent the applicant and have the representative check the appropriate box.

REPRESENTATIVE'S CONTACT INFORMATION

- Enter the mailing address for the designated representative
- Enter the email address of the designated representative, if more than one email address separate them by a comma. **(E.g. Home Email and Work Email)**
- Enter designated representative's phone number
- Enter designated representative's cellphone number if applicable, otherwise enter N/A.
- Enter the designated representative's relationship to the applicant. **(E.g. Mother, father, spouse, brother, sister, legal guardian, social worker, patient advocate.)** This information is necessary for SCPD staff to contact the representative while processing the application with questions or to obtain supporting documentation.

DEMOGRAPHIC & FINANCIAL INFORMATION

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

HEALTH INSURANCE INFORMATION

- List **all** health insurance information covering the applicant including Medicare, Medicaid, Employer health insurance, Tricare, Tricare for Life and Affordable Care Act insurance. **This information is required in order to process the application.**
- Enter the name of the policy holder.
- Enter the Insurance Company's name.
- Enter the names of people covered by this policy. **E.g. applicant, spouse, and children**.
- Enter the insurance policy number.
  NOTE 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 let us know how you found out about the Traumatic Brain Injury Fund providing the name of the person, committee, organization, or website that helped you find us.

ELIGIBILITY

- Please select either yes or no to signify if the applicant is a Delaware Resident.
- Please enter the **date of the applicant's traumatic brain injury** (or diagnosis of brain injury) occurred in month month/day day/year, year, year, year format.
- Please list the names of the **required supporting documents** that you are attaching for submission with your application. **E.g.** Hospital discharge paperwork, Rehabilitation Treatment Notes, recent treatment notes or letter from the physician (MD or DO) treating the applicant for their traumatic brain injury that includes the date of injury, a letter from the applicant's treating medical provider (MD or DO) recommending services, therapy, equipment or treatment being requested, any other treatment/diagnosis documentation. **The application cannot proceed for approval without supporting medical documentation of a traumatic brain injury.**

REQUESTED SERVICES

- Please **select** all **services** that the **applicant is requesting** funding approval from the Traumatic Brain Injury Fund that are not available through their healthcare insurance provider or any other Delaware State Agency. List specific services to the right and below each item **including the estimated cost** per service or session and number of sessions requested. Please specify services if selecting "Other Services". Provide an estimated quote of cost for each item requested. (Please attach a copy of estimates if available.) .** **Estimated cost is required for each request****
- Select "Home/Environmental Modifications" if requesting items such as an accessible ramp, accessible bathroom modification, grab bars, wider doorways, adaptive switches, accessible path to ramp, modification of materials or equipment, or specialized equipment.
- Select "Driver Rehabilitation" if applicant is requesting a driving assessment and training to determine if they are ready to drive following their traumatic brain injury.
- Select "Service Dog Acquisition & Support" if the applicant is requesting funding assistance to obtain an assessment of their ability, training, and funding to obtain a service dog that is specifically trained to assist them with certain activities they are no longer able to do independently since their traumatic brain injury.
- Select "Assistive Technology" if the applicant is requesting funding assistance to obtain specialized assistive technology. **E.g. Cognitive assistance, including computer or electrical assistive devices, that help people function following a traumatic brain injury,** modified or specialized walkers, wheelchairs, scooters, specialized eating utensils, extendable reaching devices etc.
- Select "Attendant Services" if the applicant is requesting **short-term, limited,** attendant services not covered by insurance or other state agencies.
- Select "Other Services" if there is something else the applicant is requesting being specific about what is being requested.

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

When answering the questions in this section, **DHSS services include** Medicaid & Medical Assistance, Long Term Care (LTC), Division of Services for Aging and Adults with Physical Disabilities, Division of Substance Abuse and Mental Health, Caregiver Support, Delaware's A Better Chance (DABC), Temporary Assistance for Needy Families, Community Resource and Assistance Services, Emergency Assistance Services and Division for the Visually Impaired services. **This section must be fully completed in order for the application to proceed.**

- **Select yes or no** to let us know if the applicant is currently on a waiting list for any DHSS program or services listed above 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 or services listed above but is requesting services or assistance with something not offered through that program. **If yes, please enter the type of support service being requested.**
- **Select yes or no** to let us know if the applicant (or the applicant's representative) was ever told that he or she did not meet technical eligibility standards for a DHSS program or service listed above that covers a service being 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 yes,** please select yes or no to respond whether or not the applicant or representative is 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 enter the case manager's name, phone number, and email address in the appropriate spaces.
- **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, for 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 designated representative (if any) should read (or have read to them) the **Acknowledgement Statement and Signature** agreements signifying that the applicant and/or representative have read and agree to the statements by affixing their signature below or typing their electronic signature.
- The applicant and representative (if any) should read (or have read to them) the **Electronic Signature Agreement** and **Authorization** and signify that the applicant and representative have read and agree to the statement by either affixing their signature or typing their name as their electronic signature and completing the date of their agreement.
- If the application is being submitted through U. S. Mail or being brought to our office 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 supporting document that is being attached for submission with the Traumatic Brain Injury Fund Application. If the button does not work the first time, please select it again to attach

your documents or you can select the paperclip icon located on the left side of the PDF form. You can verify that all of your documents attached correctly by selecting "View" from the menu bar and then selecting "Show/Hide" from the dropdown list and following the arrow over to select "Navigation Panes" before following the arrow over once more to select "Attachments". **The application cannot proceed without supporting documentation of a traumatic brain injury from a medical professional.**

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

- ****NOTE**** Do not leave blank spaces on the application. **If something does not apply to the applicant, please type N/A in the box** to avoid delay in processing your application.
- Approval of funds does not create any right to expect additional funds or services.

- The final step in completing an application for Traumatic Brain Injury Funds 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** beginning on the next page.

State Council for Persons with Disabilities (SCPD)

APPLICATION FOR BRAIN INJURY FUND ASSISTANCE

APPLICANT CONTACT INFORMATION

Name: Jane Q. Public

Telephone: 302-999-9999 | Street Address: 123 Popular Street

Mailing Address *(if different)*: P. O. Box 250,

Email Address: Applicant@emailprovider.com

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

AUTHORIZED REPRESENTATIVE

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

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

■ Yes ☐ No

REPRESENTATIVE'S CONTACT INFORMATION

Mailing Address: 999 Liberty Bell Avenue, Freedom Apartments, Apartment B, Wilmington, DE 19809

Email Address(es): Representative@emailprovider.com

Phone: 302-302-1234 Cellphone: 302-999-9876

Relationship to applicant: Legal Guardian

DEMOGRAPHIC & FINANCIAL INFORMATION

Date of Birth: 04/13/1950 | Gender: ☐ Male ◉ Female

Race / Ethnicity:

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

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

SSDI $800, Medicaid $500

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

$200 savings, 0 stocks, 0 bonds, $25 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
Jane Q. Public	Medicaid	Jane Q. Public	123121234
Alpha B. Public	Highmark BC/BS	Alpha & Jane	SOD987654321

SOURCE OF REFERRAL

How did you find out about the program? Sharon Lyons
SCPD Website SCPD.delaware.gov

ELIGIBILITY

Delaware Resident:
■ Yes □ No

07/04/2004
Date of Brain Injury:

TBI Diagnosis & Source/Documentation:
Enter information below and attach to application or email a copy to SCPDTraumaticBrainInjuryFund@state.de.us)

SCPD Authorization to Release Protected Information form, Christiana Hospital Discharge, Bryn Mawr Rehab Treatment Notes, Dr. GoodNews recommendation letter, Highmark BC/BS denial of coverage notice, Medicare denial of coverage notice, Dr. HelpMe's current treatment notes, Copy of most recent brain scan.

Requested Services: (check all that apply) List specific services requested including the estimated cost for each item or service requested:

■ Home/Environmental Modifications: Accessible Ramp
Estimated cost $3,000

□ Driver Rehabilitation:

□ Service Dog Acquisition & Support:

■ Assistive Technology: Communication device
$5,000

■ Attendant Services: Assistance with learning how to use communication device
10 visits at $150 each

■ Other Services – Specify:
Specialized shoes to assist with balance and walking

■ Estimated Cost (Required): $250

Delaware Department of Health & Social Services (DHSS)

DHSS services include Medicaid & Medical Assistance, Long Term Care (LTC), Division of Services for Aging and Adults with Physical Disabilities, Division of Substance Abuse and Mental Health, Caregiver Support, Delaware's A Better Chance (DABC), Temporary Assistance for Needy Families, Community Resource and Assistance Services, Emergency Assistance Services and the Division for the Visually Impaired 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 If yes, please list the type of support service?
Attendant care to assist with learning how to work communication device.

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? N/A

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? Sally Social Worker
What is your case manager's phone number? (302) 111-2222
What is your case manager's email address? Sally@DHSS@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 yes, please list who they are and what was the response?

Modern Maturity Center - Delivering meals on weals, Local Church, not able to provide assistance, Lion's Club - waiting to hear back about building ramp.

ACKNOWLEDGEMENT & SIGNATURE

ACKNOWLEDGEMENT: I understand that the TBI 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.

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 below 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 the acknowledgement above.

Signature of Applicant: Jane Q. Public	Date: 04/13/18
Signature of Representative: John Q. Sample	Date: 04/13/18

The final step in completing a Brain Injury Fund Application is selecting the black and white "**SUBMIT Application**" button located below. 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 the U.S. Mail.

Applications are accepted electronically (preferred) by using the attach documents and "SUBMIT" buttons below, by submitting through email to: SCPDBrainInjuryFund@state.de.us, 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, 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