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

I _____ am the representative for _____ for application.
(Representative's Name) (Applicant's Name)
☐ 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

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

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

☐Home/Environmental Modifications:

☐Driver Rehabilitation:

☐Service Dog Acquisition &
Support:

☐Assistive Technology:

☐Attendant Services:

☐Other Services – Specify:

☐Estimated Cost (Required):

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?

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 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:	Date:
Signature of Representative:	Date:

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**