File # ______________________________
Fund Use Only

# TRAUMATIC BRAIN INJURY FUND
# MEDICAL DOCUMENTATION FORM

***Please bring this form to your doctor for completion and return it with your application. This form must be completed and signed by a licensed medical doctor ONLY*** *(i.e. primary care doctor, neurologist, etc.).*

## SECTION I: TO BE COMPLETED BY APPLICANT OR GUARDIAN

**APPLICANT'S NAME** ____________________________________________

**APPLICANT'S ADDRESS** ____________________________________________

**APPLICANT'S PHONE NUMBER** ____________________________________________

**CONTACT PERSON** ____________________________________________
(i.e. anyone other than the applicant with whom we should speak)

I agree to the release of the medical information below to the Traumatic Brain Injury Fund for the purposes of determining eligibility. I understand that the TBI Fund reserves the right to contact listed physician for clarification of this information, and I understand that medical information will be protected under the Health Insurance Portability and Accountability Act (HIPAA).

SIGNATURE OF APPLICANT OR GUARDIAN:

____________________________________________

DATE: ______________________

**Only Original Colored Documentation Forms Will Be Accepted**

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## SECTION II: TO BE COMPLETED BY MEDICAL DOCTOR ONLY

N.J.A.C. 10:141, the statute that regulates the Traumatic Brain Injury Fund, utilizes the following definition of brain injury:

> ***"Traumatic brain injury" means an acquired injury to the brain caused by a blow or jolt to the head or a penetrating head injury/neuro-trauma that disrupts the normal brain function, where continued impairment can be demonstrated. This term does not include brain dysfunction caused by congenital or degenerative disorders, birth trauma or injuries caused by other circumstances.***

In your professional medical opinion, does the applicant's diagnosis meet this definition?

☐ YES ☐ NO

Please explain:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Nature of brain injury (i.e. stroke, traumatic brain injury, anoxia, etc.):

______________________________________________________________________

______________________________________________________________________

Circumstance of brain injury (i.e. arteriovenous malformation, motor vehicle accident, etc.):

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Will this condition require ongoing treatment and support?

☐ YES ☐ NO

Please explain:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

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Are there other medical conditions that have arisen as a direct result of the brain injury? ______

______

______

______

What brain injury related supports and/or services would you like to recommend at this time, if any (i.e. cognitive therapy, adaptive equipment, physical therapy, etc.)? Please note that a case manager may contact you for prescriptions and/or clarification regarding these supports and/or services.

______

______

______

## SECTION III: DOCTOR'S CONTACT INFORMATION

Name (printed) ______

Name (signed) ______

Address______

Phone Number ______

Fax Number ______

Medical License Number ______

If you have any questions regarding this form, please call 1-888-285-3036 (press #3).

**Please return completed application to:**

**TBI Fund**
**NJ Division of Disability Services**
**PO Box 705**
**Trenton, NJ 08625-0705**

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