State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Traumatic & Acquired Brain Injury Mini-grant Program
TABI Mini-grant Application

Applicant:		Date of Birth:	Age:
Address:			
City:	State:	Zip code:	
Telephone:	Email address:		

Have you applied for a TABI mini-grant before?	Yes ☐	No ☐
Have you received a TABI mini-grant before?	Yes ☐	No ☐
Currently receiving Medicaid ___or Medicare ___?	Yes ☐	No ☐
Are you Medicaid or Medicare eligible?	Yes ☐	No ☐
Do you have private insurance?	Yes ☐	No ☐
If yes, has this request been denied by your private insurance?	Yes ☐	No ☐

Certification statement:
I have no funds personally to make this purchase. I verify that there are no other programs available to fund this request, and acknowledge that SDS may request verification in the form of denied applications. I also give permission for the mini-grant contractor to contact me and/or the person completing the form, as indicated below.

Signature: ______________________________ **Date:** ______________

Amount requested): $______________ for equipment and/or services to meet the following needs:

☐ Medical (includes vision and hearing) ☐ Dental ☐ Psychological
☐ Physical/occupational/ speech therapy ☐ Housing ☐ Home modifications
☐ Assistance or adaptive equipment ☐ Employment ☐ Transportation
☐ Other: ____

Describe equipment/services requested. ***Attach supporting documentation****, e.g., two estimates from separate vendors, catalog page/order, or prescription from a licensed health care professional. Include the cost of shipping and enough detail to facilitate the purchase if awarded the mini-grant.*

Describe the essential need which the equipment/services will address. Provide additional documented evidence of need, if available. **List all other resources** that were explored in addition to the TABI mini-grant.

Describe how the equipment/services will increase independent functioning and integration in the community. What outcome is expected if funding is received? What outcome will take place if funding is not received?

Person completing form:	Relationship to applicant:
Telephone/email:	

Referring provider agency:	
Agency contact:	Telephone:

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Traumatic & Acquired Brain Injury Mini-Grant Program

Verification of Diagnosis

For Traumatic and Acquired Brain Injury

Applicant/Recipient Name: ______________________________ Date of Birth: ____________

The information requested by this form, which must be completed by a *physician, a physician assistant, an advanced nurse practitioner, registered nurse, speech language pathologist, occupational therapist, physical therapist, naturopathic physician or a neuropsychologist,* will assist to determine if the applicant/recipient qualifies for the TABI mini-grant program. Questions may be directed to Alaska Brain Injury Network, the mini-grant coordinator, by calling 907-274-2824 or 1-888-574-2824.

"Traumatic or acquired brain injury" means an insult from physical force or internal damage to the brain or its coverings, not of a degenerative or congenital nature, that produces an altered mental state and that results in a decrease in cognitive, behavioral, emotional, or physical functioning, as defined in Alaska Statute 47.80.590. An acquired brain injury is an injury to the brain that has occurred after birth and is not induced by birth trauma, such as a stroke.

I certify that the above named individual has a current diagnosis of Traumatic or Acquired Brain Injury, and is currently experiencing symptoms as a result of the brain injury.

Diagnoses *(Please do not use ICD-9 or ICD-10 codes):*

Primary: ____

Secondary: ____

Additional: ____

I certify that, to the best of my knowledge, the above information is true, accurate, and complete.

______________________	____________	____________
Medical Provider Signature/Credentials	Date	Provider ID #
______________________	____________	
Printed Name/Credentials	Telephone Number	

This form submitted alone does not constitute an application for funding and must be accompanied by a complete TABI Mini-Grant application in order to be considered for an award.

Practitioners may fax the completed form to *Alaska Brain Injury Network at 907-274-2826*. Thank you.

SDS 9-4 10/3/18

Alaska Brain Injury Network
121 W. Fireweed Lane, Suite 175
Anchorage, AK 99503
Tel: (907)274-2824 Fax: (907)274-2826

AUTHORIZATION FOR RELEASE OF INFORMATION

Printed Name ________________________________ **Date of Birth** ______________

Address ____

Home Telephone______________ **Cell** ______________ **Work Telephone**____________

Release To/From: ____

Telephone______________________ **Fax**________________________

Release To/From: Alaska Brain Injury Network

Telephone: 907-274-2824 Fax: 907-274-2826

Information To Be Released:

From (date)______________ **To (date)** ______________

Description of information to be released:____

____

The purpose of the release of this information is:____________________________________

____

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information in writing. If I do it won't have any affect on actions taken on this authorization before my revocation was received. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the follow date:__________________________

________________________________ ____________________

Signature of Individual or Personal Representative **Date**

________________________________ ____________________________

Printed Name of Personal Representative or Witness **Description of Personal Representative's authority**

08/2015

Additional Supporting Documentation

STATEMENT OF INJURY AND CIRCUMSTANCES

Please provide a written explanation, including the date and circumstances, of your injury:

____

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GUARDIAN INFORMATION*

If applicable, please provide information on your court-appointed conservator or guardian.

Name:____

Physical Address:____

Mailing Address:____

Home Phone:_____________________ Work phone:_____________________

Email:____

Preferred contact: ☐ Mail ☐ Phone ☐ Email

Guardianship type:

☐ Public guardian (OPA) ☐ Representative payee

☐ Full (legal) guardian ☐ Conservatorship

☐ Power of Attorney (POA) ☐ Other:______________________

Please attach a copy of court documents establishing your guardianship.