Senior and Disabilities Services Grants Unit
Traumatic and Acquired Brian Injury

Supplemental Services Application

Applicant Information

Name:	Date of Birth:	Age:
Address:	Phone Number:	Email:

Applicant Resources

Health Coverage (Medicaid, Medicare, VA, Private, list all):
Financial Support (i.e. Adult Public Assistance, Housing Voucher, etc. list all):
Monthly Income (Gross and Net): $
Sources of Monthly Income:
Monthly Budget (all expenses):

Applicant Request

Describe the need:

Have all other resources been explored? Describe in detail.
Describe the items/services being requested in detail. How will the applicant utilize them? If the request is for housing assistance, the applicant must describe how they plan to manage the monthly cost of their housing and avoid utilizing last resort funding in the future:
Describe the applicant's brain injury and the impact on their daily functioning (i.e. why is this request needed and how it will help):
What will happen if funding is not approved?
Other Comments from the applicant and/or the Resource Facilitator:

FAX or DSM completed application, Verification of Diagnosis (VOD), and estimates to:

SDS Program Manager: N/A [submitted via regional agencies]
Phone Number:
Fax:
DSM:

Internal SDS Only

Approved/Denied: Comments:	Date Signature (digital):