



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

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

Have you applied for a TABI mini-grant before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you received a TABI mini-grant before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Currently receiving Medicaid ___ or Medicare ___?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you Medicaid or Medicare eligible?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have private insurance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, has this request been denied by your private insurance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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:

<input type="checkbox"/> Medical (includes vision and hearing)	<input type="checkbox"/> Dental	<input type="checkbox"/> Psychological
<input type="checkbox"/> Physical/occupational/ speech therapy	<input type="checkbox"/> Housing	<input type="checkbox"/> Home modifications
<input type="checkbox"/> Assistance or adaptive equipment	<input type="checkbox"/> Employment	<input type="checkbox"/> Transportation
<input type="checkbox"/> 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:

Additional Supporting Documentation

STATEMENT OF INJURY AND CIRCUMSTANCES

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

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.