CHAPTER 141

TRAUMATIC BRAIN INJURY FUND

Authority

N.J.S.A. 30:6F-5 et seq., specifically 30:6F-8.

Source and Effective Date

R.2009 d.375, effective December 21, 2009.
See: 41 N.J.R. 3191(a), 41 N.J.R. 4816(a).

Chapter Expiration Date

Chapter 141, Traumatic Brain Injury Fund, expires on December 21, 2014.

Chapter Historical Note

Chapter 141, Charity Racing Days for the Developmentally Disabled, was adopted as R.1984 d.28, effective February 21, 1984. See: 15 N.J.R. 1826(a), 16 N.J.R. 375(b).

Pursuant to Executive Order No. 66(1978), Chapter 141, Charity Racing Days for the Developmentally Disabled, was readopted as R.1989 d.132, effective February 7, 1989. See: 21 N.J.R. 8(a), 21 N.J.R. 636(a). Pursuant to Executive Order No. 66(1978), Chapter 141 expired on February 7, 1994.

Chapter 141, Traumatic Brain Injury Fund, was adopted as new rules by R.2004 d.245, effective July 6, 2004. See: 35 N.J.R. 5342(a), 36 N.J.R. 3280(a). Chapter 141, Traumatic Brain Injury Fund, expired on July 6, 2009.

Chapter 141, Traumatic Brain Injury Fund, was adopted as new rules by R.2009 d.375, effective December 21, 2009. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS; REQUIREMENTS

10:141-1.1 Purpose and scope

The purpose of this chapter is to establish criteria for eligibility and to establish a standard methodology for determining the amount and type of supports and services to be allocated to individuals in the State of New Jersey who have survived a traumatic brain injury.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
Substituted "supports and services" for "financial assistance".

10:141-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Applicant" means a person who is seeking service(s) from the Fund.

"Beneficiary" means a person receiving service(s) from the Fund.

"Case management" means the administrative responsibility for oversight of the Fund beneficiary's service plan. Case management is a mandatory service component for initial applicants and recipients of Fund service(s).

"Council" means the New Jersey Advisory Council on Traumatic Brain Injury.

"Department" means the New Jersey Department of Human Services.

"Division" means the New Jersey Division of Disability Services.

"Eligible supports and services" means those goods and services that are reimbursable under the Fund. Eligible supports and services shall be directly related to the functional limitations and symptoms associated with the brain injury, or medical treatment related to the brain injury. A beneficiary may, within the financial limits of the program, receive multiple supports simultaneously.

"Excluded assets" are assets which are excluded from consideration for Fund service(s). Excluded assets include the home occupied by the individual as his or her principal residence, one automobile necessary for the transportation of the applicant/beneficiary, personal effects and household goods. Financial instruments recognized by the United States Internal Revenue Service for the purpose of retirement shall be considered excluded assets. These include 401k Plans, IRAs, and similar such instruments.

"Fund" means the Traumatic Brain Injury Fund.

"Funding year" is defined as the continuous 12-month period which begins the day after the Committee renders a decision on an applicant's/beneficiary's support plan. Expenditures in a funding year on behalf of an applicant/beneficiary shall not exceed the caps defined at N.J.A.C. 10:141-1.5(b).

"Immediate family" is defined as:

1. Biological or adoptive parent(s) or other persons who have been legally determined to be financially responsible for an applicant/ beneficiary who is under the age of 18; or

2. Persons who have been legally determined to be financially responsible for an applicant/beneficiary who is over the age of 18, including a lawful spouse.

"Liquid assets" are assets that are convertible to cash within 30 days. Liquid assets include checking and savings accounts, stocks, bonds, treasury notes and similar instruments.

"Order of selection" is defined as the criteria utilized by the Traumatic Brain Injury Fund Review Committee to establish priority for applicants to receive services in the event that the financial resources of the Fund are limited. See N.J.A.C. 10:141-1.6(b).

"Review cycle" means the schedule for the consideration and review of a batch of eligible applications by the TBI Fund Review Committee.

"Service coordination" means clinical responsibility for identifying, developing, and organizing services for a beneficiary. Service coordination is a service option available to Fund beneficiaries, the cost of which shall be applied to the beneficiary's annual and lifetime expenditure caps.

"Support plan" means a document that describes the nature, frequency and cost of services, supports, equipment or items that have been considered for payment.

"TBI Fund Review Committee" means a Committee appointed by the Division of Disability Services to review service plans, render decisions, hear appeals and review policies associated with the operation of the Fund. The Committee may also be utilized to propose solutions to problems associated with the operation of the Fund.

"Traumatic brain injury" means an acquired injury to the brain where continued impairment can be demonstrated. This term does not include brain dysfunction caused by congenital or degenerative disorders or birth trauma but may include injuries caused by anoxia due to trauma.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
In definition "Case management", substituted "initial applicants and" for "ongoing"; rewrote definitions "Eligible supports and services", "Excluded assets" and "Service coordination"; added definition "Funding year"; in definition "Support plan", substituted "considered" for "approved"; in definition "TBI Fund Review Committee", deleted "and approve applications," preceding "service plans", inserted "render decisions, hear", and inserted "review" preceding "policies"; and in definition "Traumatic brain injury", inserted "where continued impairment can be demonstrated".

Case Notes

Initial Decision (2006 N.J. AGEN LEXIS 1044) adopted, which concluded that an auto mechanic failed to present competent medical or neuropsychological corroboration sufficient to carry his burden that he suffered from a traumatic brain injury while working as mechanic in an auto repair pit area when another employee drove a car off a lift and it struck claimant on the top and back of his head as it fell, resulting in an immediate headache, although claimant continued working, and claimant did not see a doctor until 19 days after his accident; while claimant asserted that he was sensitive to lights, sounds, and smells and these sensations could cause episodes of disorientation and involuntary muscle movement, it is more likely than not that claimant's symptoms were caused by a psychiatric disorder and not by traumatic brain injury. R.R. v. Div. of Disability Services Traumatic Brain Injury Fund, OAL Dkt. No. HDS 8543-05, Final Decision (March 14, 2007).

10:141-1.3 General requirements

(a) The Traumatic Brain Injury Fund shall pay as a last resort for the cost of post acute care, services, and supports to New Jersey residents who have survived neurotrauma with a traumatic brain injury. The Fund will provide support to foster independence for its beneficiaries. The act establishing the Fund, N.J.S.A. 30:6F-5 et seq., also requires the Brain Injury Association of New Jersey to coordinate public information and prevention education related to the Fund and to traumatic brain injury.

(b) Funding and payment for services must remain within the designated disbursement caps as set forth in N.J.A.C. 10:141-1.5.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
In (a), substituted "supports" for "financial assistance".

10:141-1.4 Administration of the Fund

(a) The following procedures and methods will be used for the administration of the Fund:

1. The Division of Disability Services shall administer the Fund for the Department.

2. A committee known as the TBI Fund Review Committee shall be established within the Division of Disability Services, Department of Human Services, to implement the provisions of the Fund. Responsibilities of the Committee shall be:

i. Review of requests for services and supports under the Fund;

ii. Rendering decisions on support plans;

iii. Hearing of initial appeals;

iv. Development of policies and procedures; and

v. Identification of problems associated with the administration of the Fund.

3. The Committee shall periodically report to the New Jersey Advisory Council on Traumatic Brain Injury on the status of applications, problems, and other issues related to the Fund.

4. The Committee shall be comprised of seven members, to be nominated by their respective bodies or interest groups and appointed by the Commissioner of Human Services or designee, as follows:

i. Two TBI Advisory Council members;

ii. A family member of an individual with a traumatic brain injury;

iii. A survivor of traumatic brain injury;

iv. A representative of the Brain Injury Association of New Jersey;

v. A professional clinician in the field of traumatic brain injury; and

vi. The Director of the Division or designee.

5. The Committee shall elect a chair from its members. The chair shall direct the activity of a Committee meeting.

6. Committee members may serve for two-year terms, and may be eligible for reappointment.

7. Committee members may be replaced as necessary in the event that they are no longer able to serve.

8. Committee members must recuse themselves from any decisions related to a conflict of interest with any applicant, beneficiary or provider.

9. Committee members will not be compensated for service to the Committee, but will be reimbursed for travel and other reasonable expenses connected with performing the work of the Committee.

10. The Committee shall meet at least quarterly to review applications, and to conduct business.

11. The Division shall contract with case management companies/agencies to initially assess the applicant's appropriateness for the Fund, and to prepare a support plan in conjunction with the applicant and their family. The Division will make payments to contracted agencies/organizations based on individually negotiated rates.

12. The cost of case management will be considered as an administrative expense of the Fund, and will not to be applied against the benefits provided to a beneficiary.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
Rewrote (a)2i through (a)2v and (a)11; in (a)5, added the last sentence; and in (a)12, inserted "of the Fund".

10:141-1.5 Expenditure caps and limitations

(a) Services provided to an individual by the Fund will not exceed a lifetime total of $100,000.

(b) Expenditures for an individual shall not exceed $15,000 to be expended in any 12-month period, known as a funding year.

(c) An applicant may apply to the Fund for a waiver of these expenditure limits where the applicant can demonstrate extraordinary hardship to the satisfaction of the Committee. Hardship circumstances to be considered may include, but are not limited to, loss of income, extreme medical need, and potential functional decline of the applicant. Waivers will be at the discretion of the Committee, and will be considered only in emergent circumstances or cases of extreme hardship.

(d) Funding awarded to a beneficiary that has not been utilized at the end of a funding year shall be returned to the Fund, and shall not be counted against the beneficiary's annual and lifetime caps.

(e) A beneficiary must be a resident of the State of New Jersey during the period in which supports and services are being provided under the Fund.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
In (b), inserted ", known as a funding year"; in (c), added the last sentence; and added (d) and (e).

10:141-1.6 Eligibility for services and supports

(a) The following criteria shall be used to determine eligibility for the Fund. Responsibility for adherence to the criteria shall be vested with the Division Director, and shall remain an administrative function of the Division;

1. Medical requirements:

i. The applicant has survived a traumatic brain injury as defined in this chapter;

ii. The applicant requires, and is requesting, post acute care services/support directly related to the traumatic brain injury; and

iii. It has been established, by clinical opinion, that the provision of the requested service/support will restore, enhance or maintain function;

2. Financial requirements:

i. The requested expenditure shall not exceed established program caps;

ii. The applicant demonstrates the inability to pay for the requested services or supports from income or assets;

iii. The applicant or his or her immediate family's liquid assets do not exceed $100,000, and that those assets are otherwise committed, or not available to fund the requested services;

iv. There are no trust funds, settlements, gifts or donations for which the applicant is eligible, and which are available on a timely basis, to meet the applicant's needs;

v. There are no other funds, insurance coverage, or public or private programs for which the applicant is

eligible, to provide the requested care, services, or supports for the applicant, in a timely manner;

vi. Payment for services/supports rendered prior to the receipt of formal Committee approval, shall be ineligible for reimbursement;

vii. To the extent of funds provided to the individual, the Fund shall have first claim to any future monies received by the person with a traumatic brain injury as a result of a settlement or other payment made in connection with the traumatic brain injury; and

viii. The Fund may place a financial lien on any appreciable property purchased using Fund resources. The lien shall be no more then the amount issued by the Fund at the time of purchase, and shall be executed where:

(1) The property is being sold by the beneficiary;

(2) The beneficiary enters a long-term care facility; or

(3) The ownership of the property is transferred to an individual other then the original beneficiary; and

3. Residency requirements:

i. The applicant shall be a citizen or permanent resident of the United States, as defined by the Immigration and Nationality Act, Pub. L. 82-414, living in New Jersey, and shall be a resident at least three consecutive months prior to the date of application. Applicants shall maintain legal residence in accordance with N.J.A.C. 10:141-1.5(e) to remain eligible;

ii. The residence of a minor child shall be determined to be that of the parent(s) or legal guardian;

iii. The responsibility to furnish proof of residence shall be that of the applicant or the parent or guardian of a minor child;

iv. Absence from the State of New Jersey for a period of 12 months or more is prima facie evidence of abandonment of domicile;

v. Seasonal residents of New Jersey are excluded from eligibility. Seasonal or temporary residents of the State of whatever duration shall not constitute domicile. Migrant workers who can demonstrate a history of residence in New Jersey shall be eligible for consideration; and

vi. The Fund shall suspend the application for, or the provision of supports and services to, an individual who is or becomes incarcerated or committed to an institution as defined by 42 CFR 435.1008 and 435.1009, incorporated herein by reference, as amended and supplemented. Applications or awards may be reinstated upon release or discharge if eligibility and need continue.

(b) In the event that the Fund is unable to provide funding for all eligible individuals, persons will be given priority according to the following criteria and these criteria will be applied in descending order, and in combination, by the Committee to the eligible applicants in the current review cycle. The Committee will record the basis for its decisions. The criteria to be utilized to determine the order of selection will be:

1. Urgency of the needed service/support to restore, maintain, and/or support the function of the applicant;

2. Cost benefit to the applicant and to the Fund;

3. Demonstrated financial need. Persons with lowest income and assets will be given preference for available funds;

4. Readiness of the applicant to utilize the post-acute services/supports requested;

5. Situations where program services will be utilized as an alternative to, or substitute for, the New Jersey Medicaid TBI Waiver, or similar program, where the applicant has achieved maximum benefit from those programs;

6. The capacity of the Fund to provide the requested services within the limits of the program;

7. The absence of other brain injury services that can meet the requested need of the applicant; and

8. The applicant has been denied Fund services in previous review cycles due to lack of available funds.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
Rewrote introductory paragraph of (a); in introductory paragraphs of (a)1 and (a)2, substituted "requirements" for "need"; in (a)1ii, inserted "directly"; in (a)2vi, deleted "and" from the end; added (a)2viii; rewrote (a)3i; in (a)3iv, deleted "and" from the end; in (a)3v, substituted "; and" for a period at the end; and added (a)3vi.

Case Notes

Initial Decision (2006 N.J. AGEN LEXIS 1044) adopted, which concluded that an auto mechanic failed to present competent medical or neuropsychological corroboration sufficient to carry his burden that he suffered from a traumatic brain injury while working as mechanic in an auto repair pit area when another employee drove a car off a lift and it struck claimant on the top and back of his head as it fell, resulting in an immediate headache, although claimant continued working, and claimant did not see a doctor until 19 days after his accident; while claimant asserted that he was sensitive to lights, sounds, and smells and these sensations could cause episodes of disorientation and involuntary muscle movement, it is more likely than not that claimant's symptoms were caused by a psychiatric disorder and not by traumatic brain injury. R.R. v. Div. of Disability Services Traumatic Brain Injury Fund, OAL Dkt. No. HDS 8543-05, Final Decision (March 14, 2007).

10:141-1.7 Application process for the services/supports of the Fund

(a) The following process shall be used to apply for assistance under the Fund:

1. An individual shall contact the Division for an application to the Fund.

i. Following an initial screening to determine that the prospective applicant meets basic eligibility criteria for the Fund, Division staff will forward application forms to the applicant or designee.

ii. Division staff shall offer assistance to the applicant in completing the application if necessary.

iii. Applications shall be available in alternative formats, upon request.

iv. Requests for applications shall be taken in any commonly accepted form.

2. The applicant shall submit the application on forms provided by the Division. The application shall document identifying information, nature and date of the injury and treatments, corroboration of the injury from a medical doctor or neuropsychologist, request for assistance, including services/support and amount, financial information with supporting data and reasons why services/support cannot be provided by another resource.

3. The application shall be reviewed by Division staff. If the medical documentation does not substantiate that the applicant's disability results from a traumatic brain injury, the Division may take the following actions:

i. Request that the applicant undergo an examination performed by a licensed neurologist, neuropsychiatrist or neuropsychologist and submit a report of such examination to enable the Fund to make a clinical determination of the presence of a traumatic brain injury; and/or

ii. Request any other information or documentation required to determine eligibility. All expenses related to the requested examinations or provision of supporting documentation shall be the sole responsibility of the applicant or parent/guardian, unless financial hardship can be demonstrated. In such cases, the Fund may elect to pay the cost for the requested consultative examination or documentation.

4. Once the application is received and reviewed for completeness by Division staff, it shall be referred for assessment and follow up to a case management provider under contract to the Division. The case manager shall:

i. Meet with the applicant and make a recommendation for approval or disapproval of the application to the Division;

ii. Identify any other available resources to meet the needs of the applicant; and

iii. Assist the applicant in revising the application and in the development of the support plan.

5. All applications, with case manager recommendations, shall be referred by Division staff to the Committee to be reviewed at the first scheduled Cycle Review meeting after the application is complete. The Division shall annually publish a schedule of application deadlines related to Cycle Review meetings.

6. The application shall specify a support plan approved by the applicant (or his or her representative) and the case manager. The support plan shall identify the nature, duration and cost of services/supports.

(b) Beneficiaries who have received supports in the past may reapply as their needs dictate within the financial limits of the Fund.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
In (a)3ii, inserted ", unless financial hardship can be demonstrated. In such cases, the Fund may elect to pay the cost for the requested consultative examination or documentation"; in (a)5, substituted "the first" for "its next", and inserted "after the application is complete"; and in (b), substituted "Fund" for "program".

10:141-1.8 Approval and denial of supports/services from the Fund

(a) The following shall be the procedure and method for approval and denial for services under the Fund:

1. The Committee shall review all applications submitted for its Cycle Review meetings, and may take the following actions on each application for services:

i. Confirm eligibility and approve the support plan as presented;

ii. Confirm eligibility and modify the support plan;

iii. Confirm eligibility and hold the support plan, pending the receipt of further information; or

iv. Deny eligibility and/or the support plan as presented.

2. If the support plan is approved, the Division shall notify the applicant of its decisions, advising of initiation and completion dates, frequency and cost of the approved services/supports.

3. Denial of eligibility or modification of the support plan shall be documented in a letter from the Committee that outlines the reason(s) for the decision. Individuals denied eligibility or assistance shall have the following recourse:

i. The applicant may appeal the Committee's decision within 30 calendar days of receiving written notification from the Fund. The appeal shall include additional information to clarify or refute the Committee's decision.

ii. Upon receipt of the applicant's appeal, the Committee, at its next regularly scheduled Review Cycle meeting, will conduct an informal review of the previous decision, requesting third party opinions if necessary. The Committee shall notify the applicant of its decision

on the appeal, within a time period not to exceed 60 days.

iii. If the denial is upheld, the applicant will be informed of the right to appeal to the Office of Administrative Law (OAL) in accordance with established procedures set forth under N.J.A.C. 10:6.

(b) If funds are limited, the Committee shall invoke the order of selection, as defined in this chapter, for the purpose of prioritizing applications for receipt of services/support from the Fund. Applicants with approved support plans not fully funded shall be considered for inclusion when funds are available or at subsequent meetings of the Committee.

10:141-1.9 Service coordination under the Fund

(a) Basic or simple services/supports shall not require the ongoing involvement of a service coordinator, and can be arranged directly by the beneficiary.

(b) Elaborate or complicated services/supports shall require a service coordinator be involved with the beneficiary to arrange, monitor and evaluate services.

(c) The service coordinator shall recommend any major changes to the support plan, service provider or expenditure limits, prior to implementation of any changes which shall require Division authorization.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
Section was "Support initiation/management under the Fund". Rewrote the section.

10:141-1.10 Responsibilities of the case manager

(a) Beneficiaries meeting the requirement for case management shall receive it as a covered service of the Fund. A case manager shall:

1. Make an initial visit to the beneficiary to advise and assist the beneficiary in accessing supports and implementing a support plan;

2. Maintain telephone contact with the beneficiary and make subsequent visits on a mutually agreed basis, with Division authorization, to determine compliance with the support plan. The level of case management will depend on the complexity and cost of the support plan;

3. Contact the provider(s) of service to determine the progress of the beneficiary, and to obtain reports related thereto;

4. Be responsible for educating beneficiary/family on methods and options to maintain, enhance or increase independence;

5. Assist the beneficiary/provider in modifying the service plan as necessary, within the fiscal limits approved in the support plan; and

6. Make a final report to the Division on the outcome of supports and a recommendation if further support may be required. If additional service or support is desired/required, the beneficiary will be required to reapply to the Fund.

10:141-1.11 Payments for supports/services

(a) Payment shall be made only for those supports where no other benefit, funding, insurance coverage, subsidy or other source of payment is available.

(b) Payment shall be made by the Division upon the completion or delivery of the service or support. In the case of continuing support, payment shall be made on a periodic basis.

(c) Unless otherwise specified, payments shall be made by the Division to the provider of service upon receipt of a bill for service/support rendered. If an individual provider is employed by or under contract to an agency or institution, payment shall be made to that agency or institution. Qualified private practitioners shall be reimbursed directly.

(d) Where specified under N.J.A.C. 10:141-1.12(a) and with prior approval of the case manager and the Division, payment may be made to the beneficiary as reimbursement for services rendered, with the submission of appropriate receipts.

(e) With prior approval of the case manager and the Division, payments may be advanced to the beneficiary for service/supports if the beneficiary is unable to directly finance the service. Receipts will be required from the beneficiary to verify provision of service/support. No payments will be made for expenses incurred prior to the approval of the Support Plan.

(f) All providers of service/support must be appropriately licensed, certified according to rules and regulations of their profession/service and the State of New Jersey and/or comply with the provider requirements as specified under N.J.A.C. 10:141-1.12(a).

(g) The Division will make payments based on individually negotiated rates, or on the basis of reasonable and customary charges.

(h) Failure to comply with the provisions of these rules could result in recovery of funds or preclude future payment for support.

10:141-1.12 Eligible and ineligible supports and services

(a) The following is a list of eligible supports and services that will be considered for sponsorship under the Fund:

1. Service coordination, defined as intensive assistance with resource coordination and advocacy. Only a credentialed care manager with experience in brain injury, who is employed by an agency, shall provide services;

2. Nursing services, defined as assessment and intervention related to professional nursing practice. A registered nurse or licensed practical nurse shall provide nursing services;

3. Neuropsychiatric/neuropsychological evaluation, defined as assessment of the beneficiary's deficits and strengths with recommendations for a treatment plan if necessary. A licensed psychiatrist or psychologist with knowledge of and experience with brain injury shall provide services;

4. Medication management, defined as monitoring of prescription medication, drug interactions, and modifications related to the brain injury. A licensed physician, nurse practitioner or clinic with experience in treating brain injury shall provide services;

5. Prescription medication, defined as the provision of medications to treat/manage the traumatic brain injury, as prescribed by a physician. A licensed pharmacist/pharmacy shall provide service;

6. Behavior management, defined as a time-limited program designed to assess and treat maladaptive or aggressive behavior, which is potentially destructive to the beneficiary or others. A licensed psychologist or psychiatrist, with experience in brain injury, shall provide service;

7. Substance abuse evaluation/treatment, defined as clinical intervention to resolve alcohol and/or drug problems experienced by the person with a traumatic brain injury. A certified alcohol and drug counselor shall provide services with experience treating brain injury or a licensed alcohol/drug program;

8. Counseling services, defined as individual or group intervention to resolve adjustment problems resulting from the brain injury. A licensed psychiatrist, psychologist, social worker or counselor shall provide services;

9. Cognitive rehabilitation therapy, defined as intervention to improve memory, orientation, reasoning, appropriate verbal and behavioral responses. A professional who meets the certification standards for cognitive rehabilitation therapy as established by the Society for Cognitive Rehabilitation shall provide services;

10. Physical therapy, defined as intervention to improve or maintain physical function including muscle tone, gait and mobility. A licensed physical therapist or physical therapy assistant under supervision of a physical therapist shall provide services;

11. Occupational therapy, defined as intervention to improve or maintain fine motor coordination and dexterity related upper body functions. Services shall be provided by a registered occupational therapist or a certified occupational therapy assistant;

12. Speech-language therapy, defined as intervention to improve vocal and verbal skills, comprehension and expression, compensatory strategies, or other treatments related to swallowing. A licensed speech-language pathologist shall provide services;

13. Alternative therapy, defined as any new or non-traditional therapy not included in the other categories. Evidence must be produced by the applicant/beneficiary of the efficacy and cost benefit of the particular therapy in treating brain injury. Services can only be provided by a licensed/certified professional. Alternative treatments or therapy must have met the required Federal and/or State approvals;

14. Structured day program, defined as a professionally managed program of meaningful group or individual activities provided during the day, in or out of home, with the purpose of developing or maintaining function and independence. A licensed community residential service provider agency, Commission for the Accreditation of Rehabilitation Facilities (CARF) accredited brain injury day program, or licensed medical day care center may provide services;

15. Life skills training, defined as teaching specific instrumental activities of daily living to increase independence and function. A professional with expertise in treating brain injury shall provide services;

16. Vocational services, defined as prevocational and extended vocational support to assist the beneficiary in obtaining and maintaining employment. A vocational professional shall provide services with experience working with brain injury;

17. Educational service, defined as assistance to the beneficiary obtaining educational services including support while attending school or college, tuition payments, and other activities related to education. A beneficiary shall provide the Fund with documents verifying eligibility for the educational program, and shall demonstrate appropriate progress to be eligible for consideration of ongoing support. A professional with experience in brain injury shall provide services. Services can include payment of tuition to accredited colleges, universities, and vocational or professional schools;

18. Respite care, defined as intermittent, temporary or short-term care to provide relief to or replace an absent or incapacitated caregiver. Services shall be provided in-home by a licensed or accredited home care agency or out-of-home by a licensed nursing facility, assisted living facility or community residential services program;

19. Medical care, defined as treatment related to the traumatic brain injury. A licensed physician shall provide services;

20. Vision care, defined as eye care related to the traumatic brain injury. A licensed ophthalmologist or optometrist shall provide services with experience treating brain injury;

21. Dental care, defined as dentistry related to the traumatic brain injury. A licensed dentist shall provide services;

22. Post-acute in-patient treatment, defined as short-term 24-hour care designed to assess, treat and/or stabilize the condition of the beneficiary. A licensed rehabilitation hospital or community residential services provider shall provide services;

23. Protective legal services, defined as provision of guardianship services, special needs trust and similar services related to the traumatic brain injury where these services are approved in the service plan and determined essential to the beneficiary's well being. Only attorneys who are members admitted to a state bar shall provide services;

24. Personal care, defined as assistance with eating, bathing, dressing, personal hygiene, and activities of daily living, meal preparation and light housekeeping. A certified personal care assistant shall provide services. Payments will be made only to personal care agencies, not individual contractors;

25. Companion care, defined as non-medical care, supervision and socialization provided to the beneficiary to insure safety and enhance quality of life. An individual experienced in working with brain injury may provide services or a relative who is not a regular caregiver and does not reside in the residence of the applicant/beneficiary may provide services;

26. Housekeeping, defined as heavy and light housekeeping tasks required by the beneficiary to maintain a clean, sanitary and safe environment. A cleaning service or similar firm may provide these services;

27. Parental support, defined as support required by a parent with a brain injury when the parent is unable to perform with normal child rearing activities, or defined as support for the parent when a child with a brain injury has behavioral and management problems. Only an adult with experience and training in brain injury and childcare shall provide this service.

28. Household management, defined as support and assistance for a brain injured person in organizing the daily activities of managing a household, including shopping, meal preparation, housekeeping, bill paying, and assistance with mail. An adult with an understanding of brain injury shall provide services;

29. Money management, defined as assistance with bill paying, banking, resource investment and long term financial planning when a knowledgeable family member or friend is not available. A financial professional or unrelated adult with experience and knowledge in financial management, depending on the complexity of the activity, shall provide services;

30. Beneficiary/family education, defined as assistance to a beneficiary/family in understanding and managing the needs of a person with a brain injury. A licensed or certified professional with expertise in brain injury shall provide these services;

31. Transportation/vehicle modification, defined as payment for transportation services to provide access for the beneficiary to medical appointments, treatment facilities, vocational programs, educational programs and/or other functions approved under the service plan. Services under this service may include:

i. The modification of a vehicle specifically for the use/transport of the beneficiary if it is justified under the service plan as appropriate and cost effective. Authorized licensed vendors must provide modifications to vehicles. If the vehicle is to be operated by the beneficiary, the beneficiary must have a valid driver's license, and demonstrate capacity to maintain insurance coverage;

ii. The purchase of services from a commercial transportation vendor including authorized transportation services such as ambulances, invalid coaches, or taxis. Payments may be made to the provider of the service or to the beneficiary/family upon presentation of the proof of purchase or service; and/or

iii. Reimbursement of the cost of travel for a beneficiary. The reimbursement shall not exceed the State's mileage rate as defined by the State Treasurer, the cost of any road tolls, and parking charges with valid receipts. This provision may be invoked by the Fund where beneficiaries demonstrate clear hardship in obtaining commercial transportation, or where individual travel reimbursement is in the best interest of the Fund;

32. Environmental modifications, defined as physical adaptation to the beneficiary's home necessary to ensure the health, welfare and safety of the beneficiary and/or to enable the beneficiary to function with greater independence. Modifications may include ramps and devices to assist with activities of daily living, room alterations, or electrical and plumbing alterations to accommodate special equipment. This definition excludes adaptations or improvements to the home not directly related to the care of the beneficiary, and excludes payment of expenses related to returning the environment to its original condition in accordance with Federal and State law. Services shall be provided by companies/businesses licensed to provide the intended modification;

33. Durable medical equipment and assistive technology, defined as medical equipment includes any equipment necessary to the beneficiary's health, safety and function. Assistive technology is defined as any technological device that improves the functional independence of the beneficiary. Equipment and technology must be justified under the service plan as necessary and cost effec-

tive. This definition excludes payment for routine repairs, upgrades, or service contracts. Such expenses shall remain the responsibility of the beneficiary. Suppliers must be authorized equipment providers. Payments may be made to the provider of service or to the beneficiary/family upon presentation of proof of purchase; and

34. Housing support, defined as the provision of security deposit for rental housing, mortgage payment, or assistance in securing housing. Mortgage or rent will be honored on a one-time only basis not to exceed three months with a plan to sustain housing beyond the three-month period. This support is only to be utilized in circumstances of impending homelessness or where relocation is necessary to provide physical access. Assistance in securing housing shall be provided by a case management professional, real estate agent or agency specializing in this service. Payment shall be made to the housing provider/beneficiary as specified in the support plan upon the presentation of proof of the signed requisite contracts.

(b) The following list represents ineligible goods, services and other items that will not be considered for assistance from the Fund:

1. Acute medical care or emergency medical treatment;

2. Motor vehicles or automobiles;

3. Recreational drugs, alcohol or any illegal substances;

4. Costs associated with vacations or other entertainment or recreation expenses;

5. Any item or service that is unrelated to the diagnosis or the treatment of brain injury;

6. Entertainment equipment such as TVs, VCRs, except where there is a documented therapeutic need for such equipment;

7. Food and meals, except on an emergent basis;

8. Services furnished by relatives, except as provided for under (a) above;

9. Services furnished by individuals or agencies without appropriate licensure or certification;

10. Furniture or home furnishings, except as provided for under (a) above;

11. Child care services furnished outside the applicant/beneficiary's home;

12. Legal services other than those provided for under (a) above;

13. Any service or support available to the general public through a governmental program or agency, and for which there is no charge;

14. Items to be used as gifts including cash;

15. Payment for normal expenses related to the operation or maintenance of a vehicle;

16. Payment for cable television and internet services;

17. Payment for services needed by a beneficiary's family;

18. Payment for insurance coverage other then medical or pharmaceutical insurance;

19. Veterinary care, except for credentialed service animals; and

20. Consumable supplies associated with the use of a computer.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
In introductory paragraph of (a), substituted "sponsorship under" for "assistance from"; in (a)1, substituted "Only a" for "A"; in (a)17, inserted the second sentence; in (a)23, substituted "admitted to a state bar" for "of the New Jersey Bar"; in (a)27, substituted "Parental support" for "Child care assistance"; rewrote (a)31 through (a)34; in (b)4, inserted "or recreation"; in (b)5, inserted "or the treatment"; in (b)13, deleted "and" from the end; in (b)14, substituted a semicolon for a period at the end; and added (b)15 through (b)20.

10:141-1.13 Emergency services

(a) The Fund shall utilize the following procedure where emergency services are requested under the Fund.

1. Emergency services shall be considered in circumstances where there is a request to the Fund that cannot be heard according to the provisions of N.J.A.C. 10:141-1.7.

2. Emergency services shall be authorized at the discretion of the Division Director and shall be invoked when a delay in the provision of services would cause a direct threat to the health and safety of the applicant.

(b) Medical emergencies shall be referred directly to local hospitals or health care facilities. In no instance will acute or emergency medical services be paid for by the Fund.

(c) The Fund staff shall report all emergency service activity to the Review Committee at each scheduled committee meeting.

Amended by R.2006 d.422, effective December 4, 2006.
See: 38 N.J.R. 2015(a), 38 N.J.R. 5158(a).
Rewrote (a); and added (c).

10:141-1.14 Revenue and reporting of expenditures

(a) In accordance with N.J.S.A. 30:6F-7, the Division of Disability Services in the Department of Human Services shall prepare an annual report on the status of the Fund. The report shall include the following information:

1. The number of beneficiaries;

2. The average expenditure per beneficiary; and

3. The average income and expenditures of persons or families who received financial assistance from the Fund.

(b) The Division, in consultation with the Council, shall prepare for the Department any suggested changes in the law or regulations governing the Fund.

(c) The Department shall submit the report with any suggested amendments to the Governor and to the Senate and General Assembly committees responsible for health and human services.