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.

(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.

10:141–1.6 Eligibility for services and supports

(a) The following criteria shall determine eligibility under the Fund:

1. Medical need:

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 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 need:

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; and

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

3. Residency requirements:

i. The applicant shall be a citizen or permanent resident of the United States, living in New Jersey, and shall be a resident at least three consecutive months prior to the date of application;

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; and

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.

(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.

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.

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 its next scheduled Cycle Review meeting. 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 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.