Traumatic Brain Injury
Program Eligibility Attestation

(This form may be used in place of submittal of medical records)

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Social Security Number:
Patient Address:	Medicaid ID:	

MEDICAL PROVIDER		
Date of office visit:	Date of injury:	Was the patient under your care at the time of the injury? ☐Yes ☐No
Cause of Injury: ☐ Fall (resulting in forceful blow to head) ☐ Motor Vehicle Accident ☐ Assault ☐ Other:_____		
Method used to verify patient's brain injury: ☐Review of records ☐ Patient examination/assessment ☐ Patient self-report ☐Other:_____		

ATTESTATION

I, _____, have completed a review of the patient's records and verified the assessment and attest that the person demonstrates a need for rehabilitative services as a result of a traumatic brain injury (TBI). I understand that the State program definition of a TBI is a traumatically-acquired head injury caused by an external physical force, such as blunt/penetrating trauma or accelerating-decelerating forces. I attest that the person demonstrates a capacity to make rehabilitative progress in regaining or relearning functional skills needed to remain in the community.

_____ _____
Signature, Title Date

_____
Print Name, Title

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