Application for Provider-Based Services

Complete this application if you live outside of the Denver metro area and are seeking adaptive exercise, acupuncture, massage, chiropractic care or adaptive yoga or if you live in the Denver metro area and are seeking access to adaptive exercise or adaptive yoga. *No group classes or memberships.

Applicant Information

Date: _____

Name: _____ _____
Last First

Address: _____County: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: ( ) _____ (best number to reach me)

Email: _____

Note: Much communication with the Chanda Plan Foundation happens via email. Please provide an email address that you can access and check frequently.

Year of Birth (YYYY): _____

Guardian Name (if applicable): _____

The following information is collected for our funders, who like to know the percentage of populations serviced through our programs:

What gender do you identify with: _____

Ethnicity (optional):
Hispanic Black Asian
Indian White Other: _____

The Chanda Plan Foundation Information

How did you hear about the Chanda Plan Foundation? (*from who and/or where)*

_____

Have you ever received funding from The Chanda Plan Foundation before? YES / NO

CHECK LIST: Information on this list is mandatory in order to process your application. Please check each box to verify that each item is included and place items in the order listed below. Please keep a copy of the completed application for your records and send the original, including this check list, to the contact listed below. *Note: Materials will not be returned.*

	1. Eligibility Quiz
	2. "Direct Services Program" Application (pg. 1-8)
	3. Pre-treatment Survey (pg. 9-10)
	4. Peer Letter (listed on pg. 11)
	5. Physician Letter (pg. 12)
	6. Problem List or Face Sheet from your physician (listed on pg. 11)
	7. Attach a copy of EACH provider(s) license (listed on pg. 7)
	8. Attach a copy of EACH provider's proof of insurance (listed on pg. 7)
	9. Attach Proof of Income (pg. 6)

***Incomplete applications will not be reviewed.**

Once your application is fully complete, please:
fax your application and all items in checklist above to 1-800-533-4684
or scan and email to rachael@iamtheplan.org
or, if you do not have access to a fax machine or scanner, **mail to**:

Rachael Griffin
c/o Chanda Plan Foundation
1630 Carr Street
Lakewood, CO 80214

Please do not require a signature on delivery as this could delay receipt of application.

- COMPLETE APPLICATIONS ARE REVIEWED 4 TIMES A YEAR. TO GET INFORMATION ON THE NEXT DEADLINE, PLEASE CONTACT US AT 1-800-766-4255 x 5 or visit www.iamtheplan.org
- YOU WILL HEAR FROM US WITHIN TWO WEEKS FROM THE REVIEW DATE.
- IF YOU DO NOT HEAR FROM US WITHIN 1 MONTH OF THE REVIEW DATE, PLEASE FEEL FREE TO CONTACT US AT 1-800-766-4255 x2 REGARDING THE STATUS OF YOUR APPLICATION.

What type of disability do you have? (please circle all that apply)

- Spinal Cord Injury (para or quad), Level (i.e. C4/C5) _____
- Brain Injury (traumatic or acquired)
- Cerebral Palsy (CP)
- Spina Bifida
- Multiple Sclerosis (MS)

Date of injury or diagnosis (mm/dd/yyyy): _____

If Injured, how was your injury sustained? _____

What type of wheelchair do you utilize to function in your daily activities (manual or power?) _____

Please list any symptoms for which you receive ongoing care:

Symptoms (i.e. pain, etc)	Current treatment

(1) Physician name: _____

Phone: _____

LETTERS: **Provide two letters of support from (1) physician and (2) peer (anyone other than you or your physician) Guidelines for required physician and peer letters on page 11.**

****May use attached form for physician to complete in replacement of physician letter.****

(2) Peer or Professional name: _____

Phone: _____

Health Habits & Supplemental Information

MEDICATION: please list all prescribed, over-the-counter and supplements you take. If you need more space, please attach a list with your application.

Medication/Supplements Name (Marijuana is considered a medication)	Dose	What does this medication treat?

Do you use recreational drugs? _____ No _____ Yes
Do you have an addictive use of pharmaceutical drugs such as pain killers? _____ No _____ Yes
If you answered yes to any of the above lifestyle questions, are you interested in setting personal goals to change any of the above habits to improve your quality of life? _____ No _____ Yes

If you'd like to elaborate on your information or history and how you think alternative treatments can help, please do so here (what kind of additional information would be helpful to us?)

Exercise

Choose all that apply to your exercise routine

☐ - No Exercise

☐ - Occasional (mild or vigorous) Exercise

☐ - Frequent vigorous Exercise

Please explain:

What is your short-term health goal?

What is your long-term health goal?

How will your participation in our program help you to reach your goal(s) and quality of life?

Please list any volunteer or community service work you do:

Please list any other cash sponsorships or grants you have received in the last year:

If you were able to improve from treatments, how would it effect your participation in the community (i.e. education, workforce, volunteerism, etc.)?

Have you received these treatments you are requesting prior to this application for support? If yes, explain.

Please circle which proof of income you are including with this application:

Current vear Tax Return W-2 SSDI or SSI Statement

You **MUST** provide financial information and proof of income to be considered.

Annual Gross HOUSEHOLD Income - Please include All Household Income, i.e. parent, step-parent, spouse, adult children (circle one):

Less than $25,000 **$25,000 - $55,000** **$55,000 +**

Number of members in household: _____ _____ Adults _____ Kids

Source of Income:	**Annual Gross Amount:**
_____	$_____
_____	$_____
Total Annual Gross Household Income:	**$**_____

Assets (what do you have in savings, trusts, or investments?)

_____	$_____
_____	$_____
Total Assets:	**$**_____

Annual HOUSEHOLD living expenses:

Living Expenses	**Monthly payment**
Rent/Mortgage	$_____
Utilities	$_____
Loans (car, personal, etc.)	$_____
Food	$_____
Childcare	$_____
Medical	$_____
Transportation (gas, maintenance, auto insurance)	$_____
Medical Insurance	$_____
Other _____	$_____
TOTAL monthly living expenses	**$**_____

Total monthly living expense x 12 = Annual Living Expenses: $_____

Are you currently employed? Yes / No
If yes, how many hours/week do you work? _____

Are you currently a student? Yes / No
If yes, part time or full time? _____

Do you have private health insurance, Medicaid or Medicare? Yes / No
If yes, name of company: _____ **Policy Number:** _____
Does your insurance cover any part of the service you are seeking funding for? Yes / No

Do you have access to funds that would allow you to pay for the treatments? Yes/No
If yes, please provide details on a separate sheet of paper.
(i.e. pending legal or personal injury settlements, auto insurance due to care accident or workmen's comp claims)?

Applicant Signature: _____

Treatment Request: Itemized Cost of Request: Please be as specific as possible and get treatment plan from the provider of your choice. **If requesting funding for more than one treatment type, please list in order of priority.**

Example: acupuncture - 2 sessions/month. $45.00/session. 12 months = $1,080

TOTAL REQUEST (SUM OF TOTAL(S) ABOVE): _____

Modality Type	# of sessions/month, cost/session and # of months requesting	Total $

Please include a copy of your treatment plan developed by the provider of your choice.

Please note: Copy of provider(s) liability insurance, current license and/or certificate for modality being requested **MUST** be attached to your application when being submitted. If not included, application will **NOT** be reviewed.

Provider # 1	Name: _____ Address: _____	Phone: Email:
Provider # 2	Name: _____ Address: _____	Phone: Email:
Provider # 3	Name: _____ Address: _____	Phone: Email:

Medical Information and Publicity Release/Agreement Form:

Along with financial assistance programs to access integrative treatments, The Chanda Plan Foundation does outreach, fundraising and marketing (i.e. Chanda Plan website, documentary, brochures, etc.) work to keep the foundation information available to the community. Documentation of participant involvement and usage of material (photo, bio, etc.) is important in order to share results and the need for the foundation. Personal health information from your integrative healthcare practitioner and medical care physician will benefit our work and increase our community support. Your release to obtain and share personal health documentation is needed for this purpose.

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I authorize The Chanda Plan Foundation, and its authorized representatives, to consult with any third party who may have information bearing on my health status at the time of my application/re-application to The Chanda Plan Foundation as it relates to my use of integrative therapies.

Signature:_____

Print Full Name:_____**Date**:_____

I relieve and hereby agree to hold The Chanda Plan Foundation free and harmless from any liability arising out of the use and/or release of information; interview; photograph/videotape/film; and subsequent publication or broadcast. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility.

Signature:_____

Print Full Name:_____**Date**:_____
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Participant Health and Life Survey: Pre-Treatment

Thank you for your input. Your responses help us to assess the treatment programs being offered, finding ways to make treatments available to more participants, and identify areas for improvement.

Date: **Applicant Name:**

Place "X" in appropriate boxes below or write your response according the questions asked below. Choose only one for each question.

Question #1	0	1	2	3	4	5	6	7	8	9	10
1. Rate your current pain level. Consider the average pain experience over the previous week											

Question #2	
2. a) How many different over the counter or prescription medications are you taking now to address pain? 2 b) How many different over the counter or prescription medications are you taking now to address depression or anxiety? (Please provide the quantity as a number. We refer to medications, not the doses)	2a 2b
Question #3	
3. How many times have you visited a healthcare provider in the last 3 months? (Not including the provider/s of treatments in your Chanda Plan Foundation allocation)	

We are interested in knowing how your pain and mobility issues affect your ability to be at work, engage in volunteer activities, and function independently in activities of daily living.

Question #4	Not at all	Somewhat limiting	Significantly limiting	I am not able to work due to pain
4. To what extent is your Pain currently LIMITING your ability to work?				
Question #5	No limits	Somewhat limiting	Significantly limiting	My lack of mobility is severe due to Pain
5. To what extent is your Pain currently LIMITING your mobility?				

Question #6	Not at all	Somewhat limiting	Significantly limiting	I am extremely isolated due to Pain
6. Currently, to what extent is your Pain limiting your activities?				
Question #7	No limits	Some limits	Significant limits	Unable to function independently
7. Indicate any *limits* in your ability to function independently. Consider the activities in daily living in terms of your pain and mobility.				
Question #8	Not at all	Pain has some impact	Significant impact	Severely impacted due to pain
8. Currently, to what extent is your pain impacting your mental health?				

Thank you for your input.

Below are guidelines for the peer letter and physician letter that are required as part of the application process:

Peer letter:

- Name of person writing letter and relationship to applicant
- Applicant name
- Applicant's specific disability
- Current issues effecting applicant's health, and how integrative therapies will improve their quality of life
- Any struggle the applicant has with funding integrative therapies on their own

Letter from physician (usually from Primary Care Provider): Please include letter with the following information OR the attached physician form

- Doctor's name
- Applicant name
- Applicant's specific disability and diagnosis - this information is mandatory
- How long has doctor been their physician?
- Prescription or letter of recommendation for therapies recommended (i.e. adaptive exercise, adaptive yoga, chiropractic, massage, acupuncture), or letter stating that the physician approves integrative therapies as part of participant's treatment plan to improve quality of life (optional - some physicians are not willing to say this much)

To confirm, we at minimum need a diagnosis from your primary doctor.

Problem List or Face Sheet from physician (usually from Primary Care Provider):

A typical "problem list" in a medical record is usually a simple list of your active and past diagnoses. Most electronic medical records used by physicians today will produce a simple summary report or "face sheet" that will list a patient's diagnoses, a detailed medication list with records of refills. It is a quick snap shot summary of a patient's medical record.

Physician Release Form

Doctor's Name: ____

Patient's Name: ____

Date of last physical examination: ____

How long have you been their physician: _______________________________________

Patient's specific disability and diagnosis: _____________________________________

Does the patient use a wheelchair 100% of the time? YES / NO

Please provide a recommendation for this applicant to partake in integrative therapies and express any concerns you may have regarding applicant participating in any of the following integrative therapies based on their disability/diagnosis (adaptive exercise, adaptive yoga, chiropractic, massage, acupuncture):

____

____

____

____

____

Physician's Signature: ____

Date: ____

- -

Applicant to sign prior to giving to physician

I, __________________________ (print name), provide permission for you to give the above mentioned information to the Chanda Plan Foundation.

Applicant's Signature: ____ **Date:** ____________________

Please fax or email this completed form to the Chanda Plan Foundation:

rachael@iamtheplan.org or 1-800-533-4684.