



Application for Location-Based Services

Please note: This application is **ONLY** for individuals who are able to receive massage, acupuncture, and chiropractic care at the Chanda Center for Health in Lakewood, CO. The boundaries for Location-Based Services include the Denver Metro counties of Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Elbert, and Jefferson. If you live outside the Denver Metro area, complete our **Provider-Based Services** application. **Please do not complete if you are eligible for the Spinal Cord Injury Waiver (see below for eligibility).**

Name: _____ Date of Request: _____

Phone Number: _____ Email: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ What gender do you identify with: _____ Ethnicity (optional): _____

Physician Name: _____ Physician Phone Number: _____

Diagnosis: _____ Date of Injury/Diagnosis: _____

If injured, how did you sustain your injury: _____

If spinal cord injury, what level (i.e. C4/C5) _____ Referred By: _____

If you have private insurance, Medicare or Medicaid, please list the name of insurance and ID Number: _____

Have you received support from the Chanda Plan Foundation before? No ____ Yes ____ (year) _____

If yes, please check type of assistance: Provider-Based ____ Location-Based ____ (both) ____

What type of treatment are you requesting access to? Check all that apply.

Acupuncture Massage Chiropractic

Are you currently receiving any of these therapies, and which? _____

If yes, are you paying for these services and how much or are they being donated? _____

Do you have transportation? No ____ Yes ____

Do you need assistance transferring out of your wheelchair? No ____ Yes ____

If yes, do you have an attendant who is able to assist with this? No ____ Yes ____

Are you eligible for the Spinal Cord Injury Waiver (Medicaid Pilot Program)? No ____ Yes ____

1. Be 18 years of age or older;
2. Have a diagnosis of a spinal cord injury;
3. Have been determined to have a significant functional impairment;
4. Have been determined to be financially eligible; and
5. Reside in the Denver Metro Area, which consists of Adams, Arapahoe, Denver, Douglas or Jefferson County

Health Habits & Lifestyle

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

Medication 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?)

Please list any symptoms for which you receive ongoing care:

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

Please describe why integrative therapies are important to you?

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

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

Current year Tax Return

W-2

SSDI or SSI Statement

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: _____

Media Release

In order to provide financial assistance programs to access integrative therapies, the Chanda Plan Foundation and Chanda Center for Health does outreach, education, and marketing to share with the community. Documentation of participant involvement at the Chanda Center for Health and the usage of material is important to share results and fundraise. Examples of where materials could be shared include, but are not limited to, the website, brochures, annual report, and online social media platforms. Your release to obtain and share personal health documentation is needed for this purpose.

I agree that the Chanda Plan Foundation, Chanda Center for Health and third-party vendors may:

(Initial) _____ use my photo.

(Initial) _____ share basic personal information about me such as my name, age, and how I am involved with either the Chanda Plan Foundation or Chanda Center for Health.

(Initial) _____ share my personal health information such as how I was injured, my recovery efforts and medication use, services received at the Chanda Center for Health and other testimonial information I provide.

(Initial) _____ share my personal health information involving my care with behavioral health services.

(Initial) _____ I relieve and hereby agree to hold the Chanda Plan Foundation and Chanda Center for Health 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 of the material mentioned above. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility.

Participant Signature

Date

Guarantor/Guardian Signature

Date

Please fax your completed application to 1-800-533-4684 or scan and email to maggie@iamtheplan.org or, if you do not have access to a fax machine or scanner, **mail to:**

Maggie Cavanagh
c/o Chanda Plan Foundation
1630 Carr Street, Lakewood, CO 80214

Location-Based services at the Chanda Center for Health has been made possible through generous donors of the Chanda Plan Foundation. The intent is to provide assistance for those demonstrating a genuine financial need to receive integrative therapies. Funding is limited and all recipients are requested to develop a treatment plan with location-based providers.