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. 11)
	4. Peer Letter (listed on pg. 9)
	5. Physician Letter (pg. 10)
	6. Problem List or Face Sheet from your physician
	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 admin@chandacenter.org
or, if you do not have access to a fax machine or scanner, **mail to**:

Hailey Strampel
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 7 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 x 2 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 year 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:

Media Release

In order to provide financial assistance programs to access integrative therapies, the Chanda Plan Foundation does outreach, education, and marketing to share with the community. Documentation of participant involvement with the Chanda Plan Foundation 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 and affiliated 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.

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

(Initial) _____ I relieve and hereby agree to hold the Chanda Plan Foundation 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

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.

1. **First Name:**_____

   Last Name:_____

2. Timing of survey *(CFP Staff will check this item)*
❑ Pre

3. **How would you rate your average experience of pain over the past week?**

	No pain			Mild pain		Moderate pain			Severe pain		Very severe		Worst pain
Overall pain	0	1	2	3	4	5	6	7	8	9	10		
Nerve pain	0	1	2	3	4	5	6	7	8	9	10		
Muscle pain	0	1	2	3	4	5	6	7	8	9	10		

4. **Please tell us the number of over-the-counter and prescription medications you are taking to address the following conditions: (count the number of medications, *not the dose or number of pills*).**

	To address pain	To address depression or anxiety
Prescription medications		
Over the counter medications		

4a. **Please tell us how many milligrams (mg) per day you are taking of each of the following opioids.**
(Note this is mcg/hour for Fentanyl transdermal)

_____ Codeine	_____ Morphine
_____ Fentanyl transdermal (*in mcg/hr)	_____ Oxycodone
_____ Hydrocodone	_____ Oxymorphone
_____ Hydromorphone	_____ Tapentadol
_____ Methadone	_____ Tramadol

5. **How many times have you visited a healthcare provider in the last three months, *not including integrative healthcare providers*?** ☐

6. **To what extent is your current health…**

	Not at all	Somewhat	Significantly	Completely
Limiting your physical mobility?	1	2	3	4
Limiting your social activities?	1	2	3	4
Negatively impacting your mental health?	1	2	3	4
Reducing your ability to function independently?	1	2	3	4

7. **To what extent are the following limiting your ability to work for pay…**

	Not at all	Somewhat	Significantly	Completely
Concern about losing benefits?	1	2	3	4
Level of physical mobility?	1	2	3	4
Pain?	1	2	3	4
Transportation challenges?	1	2	3	4