



**Improving the quality of life for individuals with physical disabilities by providing education and programs to access integrative therapies.**

Application Date: \_\_\_\_\_

*Applicant Information*

Name: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Preferred Phone #: ( ) \_\_\_\_\_ (best way to reach me)

Email: \_\_\_\_\_

Guardian Name (if applicable): \_\_\_\_\_

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

Gender: Male / Female 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

If yes, what year did you receive the funding? \_\_\_\_\_

what amount was the funding? \$ \_\_\_\_\_

what was the grant used for? \_\_\_\_\_



**\* Please Note: Incomplete applications will not be reviewed.**

*Disability & Health Information*

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

- Spinal Cord Injury (para or quad)
- Multiple Sclerosis (MS)
- Cerebral Palsy (CP)
- Spina Bifida
- Muscular Dystrophy (MD)

**Date of injury or diagnosis (mm/dd/yyyy):** \_\_\_\_\_

What form of medical device (i.e. wheelchair, walker, cane, etc.) do you utilize to function in your daily activities? \_\_\_\_\_

Please list any conditions for which you receive ongoing care.

Conditions: caused by your disability (i.e. muscle atrophy, etc.)	Symptoms (i.e. pain, etc)	Current treatment for this condition.

Primary Physician:  
(last and first name)

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Applicant Name: \_\_\_\_\_



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 Name	What does this medication treat?

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?):

*Health Habits & Supplemental Information*

**Exercise**

Choose all that apply to your exercise routine

- No Exercise

- Occasional (mild or vigorous) Exercise

- Frequent vigorous Exercise

Please explain:

Applicant Name:

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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)?

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:

Please describe how this treatment will improve your quality of your life:

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

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

Applicant Name: \_\_\_\_\_

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Financial Information - All information provided is confidential

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

In addition, for financial clarity, you can attached additional information such as household bill receipts.

**Annual Gross HOUSEHOLD Income**

**Source of Income:** please include All Household Income (parent, step-parent, spouse, adult children)

Annual Gross Amount:

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Total **Annual** Gross Household Income: \$ \_\_\_\_\_

**Assets** (what do you have in savings 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, is it part time or full time?** \_\_\_\_\_

**Do you have private health insurance?** Yes / No

**If yes, name of company:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

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*Treatment Request Details*

**Itemized Cost of Request: Please be as specific as possible and get treatment plan from the provider of your choice. It is required to include a copy of your treatment plan with submitting this application.**

*Example: treatment desired - # of sessions/month. \$ amount/session. # of months = Total request*

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

Treatment	Cost per treatment	# of treatments per month requested	# of months requested	Total
1				
2				
3				

**TOTAL REQUEST:** \_\_\_\_\_

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

<b>Provider # 1</b>	Name: _____ Address: _____	Phone: _____ Email: _____
<b>Provider # 2</b>	Name: _____ Address: _____	Phone: _____ Email: _____
<b>Provider # 3</b>	Name: _____ Address: _____	Phone: _____ Email: _____

**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.

Applicant Signature \_\_\_\_\_

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*Release/Agreement Form*

Along with financial assistance programs to access alternative 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 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.

**With this knowledge, I choose the following (Please choose one):**

- As a participant of The Chanda Plan Foundation, I authorize permission for The Chanda Plan Foundation to collect information from my personal alternative practitioner and/or medical care physician regarding my health status and/or improvement since using integrative treatments and usage of my photo, bio toward actions mentioned above.
- As a participant of The Chanda Plan Foundation, I do not authorize permission for The Chanda Plan Foundation to collect information from my personal complementary alternative practitioner and/or medical care physician regarding my health status and/or improves since using alternative treatments and usage of my photo, bio toward actions mentioned above.

**I understand if I am chosen to participate in The Chanda Plan Foundation's Quality Of Life program, I am required to engage in a minimum of 2 treatments per month. I understand that consecutive treatments are most effective and provide the best opportunity for treatments to reduce a participant's health condition(s). If I fail to meet this requirement, I understand that I will be withdrawn from the Quality Of Life program. Unforeseen situations do occur... If a documented circumstance (i.e. hospitalize, severe illness, etc.) is preventing me from accessing treatments twice a month, I will notified The Chanda Plan Foundation right away. A letter from my primary physician will be provided to The Chanda Plan Foundation in order for my participation to remain reactive**

I also agree to fill out a post-quarter survey (every 3 months), which will be provided to me by The Chanda Plan Foundation. If I fail to complete my surveys in a timely manner, I understand that I will be withdrawn from the program.

My best form of contact for evaluation purposes is **(please circle one)**

**PHONE      EMAIL      MAIL**

**Please provide the appropriate contact information from your choice above (i.e. phone number, email address or mailing address) on the line below:**

Applicant Name (Print): \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date: \_\_\_\_\_



## Pre-Treatment Survey

Client's Name:	Rating (Place checkmark in appropriate boxes below)										
Question #1	0	1	2	3	4	5	6	7	8	9	10
<b>1. Rate your current pain level as an overall average</b>											
Question #2	0-1		2-4		5-7		8-10		>10		
<b>2. Number of pain medications you are taking</b>											
Question #3	Not working		Looking for work		<20hr/week		20-39hr/week		Fulltime 40hr/week		
<b>3. Number of hours you are presently working or volunteering</b>											
Question #4	None		Once		Twice		Quarterly (every 3mnths)		Monthly		
<b>4. Number of <u>annual</u> visits to a healthcare physician or practitioner...</b>											
Question #5	YES						NO				
<b>5. Pain limits your ability to work</b>											
Question #6	YES						NO				
<b>6. Pain limits your mobility</b>											
Question #7	YES						NO				
<b>7. Pain has a negative impact on social activities</b>											
Question #8	YES						NO				

Once your application is fully complete, please mail your application to The Chanda Plan Foundation at:

Attn: Carolyn Bachamp  
Medical Staff Department  
c/o The Chanda Plan Foundation  
PO Box 9019 N Broadway & Balsam  
Boulder, CO 80301

- COMPLETE APPLICATIONS ARE REVIEWED 4 TIMES A YEAR. TO GET INFORMATION ON THE NEXT DEADLINE, PLEASE CONTACT US AT 303.246.4290.
- YOU WILL HEAR FROM US WITHIN TWO WEEKS FROM THE REVIEW DATE.
- IF YOU DO NOT HEAR FROM US WITHIN 2-3 MONTHS OF SUBMITTING YOUR APPLICATION, PLEASE FEEL FREE TO CONTACT US AT 303.246.4290 REGARDING THE STATUS OF YOUR APPLICATION.

The Chanda Plan Foundation  
[ch@thechandaplanfoundation.org](mailto:ch@thechandaplanfoundation.org)  
303.246.4290

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