



BIO-THERAPEUTICS EDUCATION & RESEARCH FOUNDATION

36 Urey Court, Irvine, CA 92617 ~ Phone: 949-679-3000 / Fax: 949-679-3001 ~ www.BTERFoundation.org

Application for Patient Assistance Grant

Please complete this form and return it to any of the addresses above. Awardees may be eligible for subsidy of biotherapy products or free materials, depending upon individual needs and available resources.

By signing this form, the applicant (patient/representative) agrees to the terms of this grant, including the anonymous tracking of results of this program. The applicant also grants permission to their health care provider, insurance company, and all others involved with their health care, to release the information necessary to complete this application.

Unless this box is checked () , the applicant also grants permission to be included in a registry held by the BTER Foundation, for the purpose of contacting applicants about relevant studies and opportunities.

Personal information is not sold or distributed. Programmatic and anonymous clinical information may be analyzed, summarized, and/or published. Contact the BTER Foundation for any questions related to this Program.

Patient Name (printed) Signature Date

1. Patient demographics and financial information -

Name of patient: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____ E-mail: _____

Insurance carrier (check all that apply):

- Medicare
- Medicaid
- HMO: _____
- PPO: _____
- None
- Other: _____

Approximate annual income:

- < \$10,000/year
- \$10,000 - 25,000
- \$25,000 - 50,000
- \$50,000-75,000
- \$75,000 - 100,000
- > \$100,000

Amount of support requested (estimated / actual / unknown; therapy not complete): _____

For the following services:

Biotherapeutic supplies (maggots / leeches (not currently available) / other: _____)
Other supplies or services: _____

Has therapy already begun? _____ Completed? _____

Duration or number of treatments (estimated / actual): _____

2. Care provider information -

Physician: _____

Facility: _____

City: _____ State: _____ Zip code: _____

Name of contact: _____ Phone: _____ Fax: _____

3. Clinical Information -

Type of wound: _____

Reason for selecting biotherapy: _____

Treatments previously tried: _____

Alternative therapy if biotherapy not available: _____

Anatomic site of treatment: _____

Underlying medical conditions / illnesses: _____

4. Name and signature of person(s) completing this form

Name (printed) Signature Date

Relationship to Patient