MONARCH LABS
Living Medicine

17875 Sky Park Circle, Suite K, Irvine, CA 92614 ~ Phone: 949-679-3000 / Fax: 949-679-3001
www.MonarchLabs.com

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 Monarch Labs, 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 Monarch Labs for any questions related to this Program.

______________________ ______________________ ___________
Patient Name (printed) Signature Date

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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): ________
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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