AMERICAN HIRUDOTHERAPY ASSOCIATION (AHA)
451 Crestdale Ln # 82, Las Vegas, NV 89144-1008, USA, Phone: 702-883-5343 / Fax: 1-888-825-0793
http://www.americanhirudotherapyassociation.org

BIO-THERAPY WITH MEDICINAL LEECHES

support@americanhirudotherapyassociation.org

Application for Client Assistance Grant

Please complete this form and return it to the above address. Applicants may be eligible for subsidy of hirudotherapy sessions nationally and internationally, depending upon individual needs and available resources. Please make sure that you are the AHA Member before you start this application. It applies to all involved parties including clients, hirudotherapists, doctors, & corporate owners.
By signing this form, the applicant/representative agrees to the terms of this grant, including the anonymous tracking of results of this program.

The applicant also grants permission to the AHA Board Members, Corporate members & Practitioners, to release the information in this application.

Please check this box (□), since the applicant also grants permission to be included in a registry held by the American Hirudotherapy Association 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 Association for any questions related to this Client Assistance Program.

_____
Client Name (printed) _____
Signature _____
Date _____Witnessed by: _____
_____

1. Client demographics and financial information -

Name of client: _____ Age: _____Gender:_____
Married: _____ Single _____ Common marriage _____Living alone _____
Address:
_____
City: _____ State: _____ Zip code: _____Country _____
Phone: _____ Fax: _____ E-mail: _____

Insurance carrier (check all that apply, if any):
□ Medicare □ Medicaid
□ HMO: _____ □ PPO: _____
□ None □ Other: _____

Approximate annual income:

□ Less than $10,000/year □ $10,000 - 25,000 □ $25,000 - 50,000 □ $50,000-75,000
□ $75,000 - 100,000 □ More than $100,000

Amount of support requested through Hirudotherapy Practitioner/Organization (□ estimated / □ actual / □ unknown if without Hirudotherapists yet):

_____
_____
_____

Information from the leading hirudotherapist about suggested hirudotherapy, number of sessions, estimated number of medicinal leeches if in therapy already or planning; First basic information for the following: □ leeches □ other supplies or services

_____
_____
_____
_____
_____
_____

Has therapy already begun? _____ in progress _____ Date Started _____
Duration: number of treatments (□ estimated / □ actual): _____
Number of leeches _____ estimated _____actual _____

2. Hirudotherapists/MD information -
Name/Title:

_____
Certified Hirudotherapists _____MD _____USA _____ Other Country _____
_____
Facility Name: _____
_____
Government approved: _____Yes _____ No _____ Other_____
_____
_____
City: _____State: _____Zip _____Country _____

Name of contact: _____ Phone: _____ Fax: _____
E-mail:_____

3. Health Information from MD/ Main complain -

_____
_____
_____
Reason for selecting hirudotherapy:
_____
_____
_____
Alternative & complementary help previously tried: _____Yes____ No; When/ location
_____by whom_____
_____
MD recommendations, if any or Client's personal choice & decision:
_____

Client referred by: _____

_____

_____

Hirudotherapy Applications/Anatomic site of placement:

_____

_____

_____

_____

Underlying health conditions / illnesses documented:

_____

_____

_____

Client: Please attach a copy of your picture ID and SS card; please attach copies of medical diagnosis, diagnostic test, most recent blood tests and other information that will be helpful for AHA's decision. Please make your statement to AHA regarding your specific financial situation and the need of assistance:

_____

_____

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_____

4. Hirudotherapists and MDs: please disclose and mark with your initials/signature if you will be writing on application on the client's behaved. Attach the copies of client's picture ID, SS Card and Insurance card (if applicable). Attach a copy of your picture ID and business card. Contact AHA if any questions occur.

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

_____ _____ _____

Name (printed) Signature Date

_____ _____ _____

Relationship to Patient Witnessed by Date

AMERICAN HIRUDOTHERAPY ASSOCIATION (AHA) is promoting a Good Cause of Giving & Getting – our mission statement: "Making Hirudotherapy Affordable to ALL"