GRANT APPLICATION

Spring 2017

Version 1.0
Approved 08/2016

Grant Information

The Hope for Fertility Foundation provides up to $5,000 per funded family to help with costs of domestic adoption and medical fertility treatment. The only restrictions for applying are:

1. You MUST be legally married
2. You MUST have a diagnosis of infertility from your doctor
3. You MUST be a legal permanent US resident

There are no other restrictions currently. The grant is offered twice per year, and the number of applications funded as well as the amount of funding depends on the success of The Hope for Fertility Foundation's fundraising activities (i.e. the more we raise, the more we can give away).

Grant applications will be **reviewed** and selected **twice per year** - once in the spring and once in the fall.

Both portions of application (as well as the medical history forms) must be **received** by the indicated deadlines. Incomplete or late applications will not be reviewed until all materials are received. The grant application and the medical history forms must be mailed into The Hope for Fertility Foundation's address: 1512 West 525 South Orem, UT 84058. Items that are faxed or emailed will not be considered.

Spring Grant Dates

Applications Due by **February 1, 2017** and will be announced by **June 1, 2017**.

Fall Grant Dates

Applications Due by **July 1, 2017** and will be announced by **November 1, 2017**.

Submission Checklist

Before filling out the above application, make sure you meet the criteria set out in the "Grant Information" section of our website. If so, you must submit the following information with your completed application:

APPLICATIONS MUST BE IN OUR HANDS BY THE DEADLINE. NO LATE SUBMISSIONS ACCEPTED.

1. A personal statement (maximum 2 pages) indicating why you have chosen to apply for The Hope for Fertility grant. Include information about your efforts to conceive, your financial circumstances, and why you would be a worthy candidate. We welcome photos. Please limit this to 2 photos.
2. Application fee of $50. Make check payable to The Hope for Fertility Foundation. We do NOT accept money orders. Personal Check or Cashier's Check only. Applications submitted without a fee will NOT be reviewed.
3. Signed release form (see below)
4. Medical packet: Your physician MUST complete the medical portion of the application (pages 9,10, and 11.) **It is the applicant's responsibility to obtain these pages from the physician and include them with the application.**
5. Mailing hints: Please avoid a last minute rush and submit your application as early as possible. PLEASE DO NOT SENT APPLICATIONS THROUGH CERTIFIED MAIL (requires signature on delivery).
6. Fertility clinics and physicians may require weeks to complete the medical form. Please allow your doctor enough time to complete the form so you can include it with your application. An application is NOT complete without the medical forms.
7. WE DO NOT ACCEPT APPLICATIONS SUBMITTED VIA FAX OR EMAIL.
8. Scrapbooks, posters, creative photo books are unnecessary. We do NOT return submissions.
9. PLEASE FOLLOW THE ABOVE GUIDELINES. SEND ONLY WHAT IS REQUIRED. DO NOT INCLUDE PAGES OF MEDICAL HISTORY, ETC.

The Hope for Fertility Foundation receives many applications each cycle. We are limited by the amount of funds that are donated/fundraised. Please know that we CANNOT fund all those who apply, even though we would love to.

THE HOPE FOR FERTILITY FOUNDATION

Grant Application

Grant Application registration fee is $50 and is NON REFUNDABLE. We encourage you to read the entire application prior to paying. If you decide to withdraw your application for **ANY REASON** we would be happy to send you a tax deductible donation receipt for your registration amount, but cannot refund the registration fee. We apologize for any inconvenience this may cause.

NEXT APPLICATION DEADLINE: February 1, 2017

Send completed application and application fee to:
The Hope for Fertility Foundation
1512 West 525 South
Orem, UT 84058

( ) I am a 1st time applicant ( ) 2nd time applicant ( ) 3rd+ time applicant
NOTE: All applications MUST contain a non-refundable $50 fee.

How did you hear about The Hope for Fertility Foundation? _____

PERSONAL INFORMATION

Name of Applicant: _____ Partner's Name:_____
Home Address:_____
City:_____ State:_____ ZIP:_____
Applicant's Age:_____ Applicant's Partner's Age:_____
Email Address:_____
Day Phone (____)_____-_____ Evening Phone (____)_____-_____
Age(s) of children in household (if any):_____
If selected, what amount could you contribute to treatments? $_____

EMPLOYMENT HISTORY *(Please provide information for past 2 years)*

Applicant's Current Employer:_____
Employer's Contact Information:_____
Job Title:_____ Dates of employment:_____
Annual Salary: $_____ Work Phone (____)_____-_____

Applicant's Previous Employer:_____
Employer's Contact Information:_____
Job Title:_____ Dates of employment:_____
Annual Salary: $_____ Work Phone: (____)_____-_____

EMPLOYMENT HISTORY *(Continued)*

Partner's Current Employer:_____

Employer's Contact Information:_____

Job Title:_____ Dates of employment:_____

Annual Salary: $_____ Work Phone: (____)_____-_____

Partner's Previous Employer:_____

Employer's Contact Information:_____

Job Title:_____ Dates of employment:_____

Annual Salary: $_____ Work Phone: (____)_____-_____

CRIMINAL BACKGROUND

Have you (or your partner if applicable) been convicted of a felony or misdemeanor? If so, please explain:_____

_____

_____

_____

INFERTILITY HISTORY

How long have you been attempting to conceive? _____

Have you ever been pregnant? _____ When? _____

Please include any other relevant information regarding your history of infertility. (IUI, Clomid, IVF, etc.) _____

_____

_____

_____

_____

_____

FINANCIAL INFORMATION *(W-2's may be submitted in lieu of Part A.)*

( ) Last two years W-2s Included (Please include for applicant and partner, if applicable)

Part A.

Total monthly household income before taxes: _____

Monthly income from salary, wages: _____ Self-employment income: _____

Income from overtime, commissions, tips, bonuses, etc.:_____

Dividends, interest:_____ Trusts and annuities:_____

Pensions and retirement funds:_____ Social Security income:_____

Disability, unemployment insurance, or worker's compensation:_____

Public assistance (welfare):_____ Income producing property: _____

FINANCIAL INFORMATION (Continued)

Part B.

List ALL Joint and Individual Assets:

1. List all property owned including property location(s) and fair market value of each:
   _____
   _____
   _____
2. Saving account(s) balance:_____
3. Money market accounts and CD values:_____
4. Motor vehicles (year, make, model, approximate Blue Book Value):
   _____
   _____
   _____
5. Liabilities (mortgage, credit cards, loans, creditors, etc.) Include amounts owed:
   _____
   _____
   _____
6. Are you or have you ever been in collection? _____

ATTESTATION

By my signature below, I certify the information I provided on and in connection with this application is true, accurate and complete. I also understand that any false statements or deliberate omissions on this document or any other document I file with The Hope for Fertility Foundation may be grounds for disqualification from the grant application process.

_____	_____	_____
(Applicant's Signature)	(Partner's Signature)	(Date)

The following form allows The Hope for Fertility Foundation to use excerpts from your personal statement. No last names will be used.

RELEASE FORM

The Applicant hereby assigns and grants The Hope for Fertility Foundation (Foundation) and its legal representatives the irrevocable and unrestricted right to use excerpts in whole or in part from the Applicant's personal statement for editorial, trade, advertising, or any other purpose and in any manner and medium; to alter the same without restrictions; and to copyright the same. The Applicant hereby releases the Foundation and its legal representatives and assigns from all claims and liability relating to said excerpts. Any person mentioned in Applicant's personal statement shall be deemed to have consented to the use of their name, image, or likeness by Applicant and/or Foundation and Applicant shall defend and indemnify the Foundation from and against any claims that any of Applicant's friends, family or other persons mentioned in the personal statement may assert against the Foundation arising from, or related to, the use of any name, image, or likeness of Applicant's friend, family or other person mentioned in the personal statement by Foundation. Surnames will NOT be used so as to protect the identification of any of the above.

_____ _____

(Applicant's Signature) (Date)

Print Name _____

_____ _____

(Partner's Signature) (Date)

Print Name _____

I give my permission for The Hope for Fertility Foundation to contact my physician and/or clinic's business manager.

_____ _____ _____

(Applicant's Signature) (Partner's Signature) (Date)

All information submitted to The Hope for Fertility Foundation will be held in the strictest confidence and viewed only by the board members. We thank you for your interest in The Hope for Fertility Foundation and wish each and every one of you the best in your attempt to build your family. No forms (photos, letters, etc.) will be returned.

AUTHORIZATION FORM

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize _____ to disclose certain protected health
(name of clinic)
information about me to The Hope for Fertility Foundation.

This authorization permits the above mentioned clinic to disclose health information about me (and my partner, if applicable) for the purpose of applying for a grant from The Hope for Fertility Foundation.

Clinic Name: _____ Clinic Phone: (____)_____-_____
Address:_____
City:_____ State:_____ ZIP:_____
Physician: _____

Patient's Signature: _____ Date: _____
Print Patient's Name: _____

Partner's Signature: _____ Date: _____
Print Partner's Name: _____

THE HOPE FOR FERTILITY GRANT APPLICATION

MEDICAL EVALUATION FORM

(Pages 9, 10, and 11 are to be completed by the physician.) PLEASE FEEL FREE TO ADD ANY STATEMENT IN SUPPORT OF THE PATIENT'S GRANT REQUEST.

Patient Name: _____

Height: _____ Weight: _____ BMI: _____

Patient Age: ___ DOB: _____ Gravida: _____ Para: _____ Abortus: ____

Partner Age: ____ Does either smoke? ( ) Yes ( ) No

Length of infertility (months trying): _____

Cause of infertility (choose all the apply):

( ) Male ( ) Tubal/Uterine ( ) Ovarian ( ) Unexplained ( ) Pregnancy Loss ( ) Other

Prior Treatments:

Number of Prior IUI's: _____ Outcome: _____

Number of Prior IVF's: _____ Outcome: _____

# of eggs: _____ # fertilized: _____ # transferred: _____ # in storage: _____

Female Evaluation

Medial problems: _____

Current medications: _____

Surgical history: _____

Ovarian reserve: Day 3 FSH/E2: _____ AMH _____ Antral Follicle Count: _____

Tubal/Uterine:

HSG result: _____

Hydro sonogram: _____

Hysteroscopy: _____

Male work-up: Semen analysis (dates): _____

Volume: _____(ml) Sperm concentration: _____(Million/ml)

Motility: _____

Normal morphology: _____ (indicate WHO or Kruger strict criteria)

What is your recommendation for treatment for this patient?

_____

_____

Type of medications and dose you plan to use: _____

_____

_____

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MEDICAL EVALUATION FORM (Continued)

Total costs EXCLUDING MEDS: _____ (not including any discounts)

Physician cost: _____ Lab fees: _____ Anesthesia: _____

Other: _____ Includes ISCI? ( ) Yes ( ) No Cryopreservation? ( ) Yes ( ) No

Approximate medication cost: _____

Portion to be covered by insurance (if any): _____

Additional Information:_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

THIS FORM AS BEEN COMPLETED BY:

Physician: _____

Clinic: _____

Address: _____

_____

Phone: (____)_____-_____ Email: _____

The above diagnosis and costs are accurate to the best of my knowledge.

_____ _____

Physician's Signature Date

Thanks!

Dear Physician,

You have been given the enclosed medical form because your patient is applying for a Hope for Fertility Foundation grant.

The Hope for Fertility Foundation is a 501c(3) charity founded in 2016. Our mission is to grant financial assistance to those struggling with the high costs of infertility treatments such as artificial insemination, in vitro fertilization, egg and sperm donation, embryo donation, adoption, and gestational surrogacy. The Hope for Fertility Foundation's award policy is to make up the gap between the total costs and what the patient can contribute. With this in mind, I am inquiring about the possibility of your providing a discount on services, whether this be a reduction in fees or a free treatment cycle. *Please note: You are obligated to honor the discount ONLY IF the patient is selected as a Hope for Fertility Grant recipient.*

__ Our clinic would be willing to offer the grantee a $_____ grant.

__ Our clinic would match The Hope for Fertility Foundation's grant up to a maximum of $_____.

__ Our clinic would offer a grant of _____ % off the total cost (physician's fee and lab costs) excluding medications.

Additional costs if not included in above discount:
Anesthesia fee _____ Facility fee _____ ICSI _____
Cryopreservation _____ Other _____

__ We are unable to offer this patient a grant.

If The Hope for Fertility Foundation has questions about financial details for this patient, who should be contacted?

First name: _____ Last name: _____
Department at clinic: _____
Phone: _____
Email: _____

As a physician who witnesses firsthand the frustration of couples facing infertility, I hope you will join The Hope for Fertility Foundation in helping the applicant. With the advance of technology, it is solely money which separates a couple from their dream of building their family.

Please feel free to contact me with any questions. Our website (www.hopeforfertility.org) has information on our process and future success stories.

Thank you,

Chase R Palmer (Board President)

The Hope for Fertility Foundation **Phone:** 385-269-2846 **Email:** chase.palmer@hopeforfertility.org