

CHANCE TO HOPE
FERTILITY TREATMENT GRANT

CHECK-LIST:

1. _____ Application with included medical records and employment release forms
2. _____ Letter from treating Reproductive Endocrinologist verifying diagnosis and treatment plan
3. _____ Notice of Privacy Practices
4. _____ Narrative expressing financial reasons for grant and how money would be used.
5. _____ Narrative answering "why you believe you are a prime candidate"
6. _____ Copy of most recent IRS tax return (at least two); pay stubs from both individuals
7. _____ Financial Form
8. _____ Copy of birth certificate/green card/passport
9. _____ Copy of marriage license
10. _____ Photo of yourselves
11. _____ Copy of insurance card, front and back

CHANCE TO HOPE FERTILITY TREATMENT GRANT APPLICATION

"Standing Together in Love"

Chance to Hope is a nonprofit organization that offers grants to assist qualified couples with fertility treatment or adoption. Although we would love to help each and every one of you, not all applicants will receive grants. Disbursement of grants will be at the discretion of the organization. Partial and Full Grants will be awarded. Funds will be disbursed directly to the Fertility Center or Adoption Agency. Best of Luck and Thank You for participating in our Application Process!

Personal Information

Husband's Name: _____
Last First Middle

Wife's Name: _____
Last First Middle

Home Address: _____
Street Address Apartment #

City/State Zip County

Dates of Birth: _____
Husband Wife

Social Security Numbers: _____
Husband Wife

E-mail Address: _____

Date and Place of Marriage: _____

Children in your Household: _____
Name Date of Birth

Name Date of Birth

Attach an extra page if necessary.

Although consideration will be given to couples with children, preference will be given to those without.

Employment Information

Husband's Employer:

Name of Current Employer		Date Employment Began
Street Address		
City	State	Zip
Job Title		Work Telephone Number
Name of Previous Employer		Dates of Employment
Street Address		
City	State	Zip
Job Title		Work Telephone Number

Attach an extra page if necessary to list employment history for the past 5 years.

Wife's Employer:

Name of Current Employer		Date Employment Began
Street Address		
City	State	Zip
Job Title		Work Telephone Number
Name of Previous Employer		Dates of Employment
Street Address		
City	State	Zip
Job Title		Work Telephone Number

Attach an extra page if necessary to list employment history for the past 5 years.

Education Information

Husband's Education/Profession: _____

Last School Attended: _____ Date of Graduation: _____

Degree Earned: _____

Wife's Education/Profession: _____

Last School Attended: _____ Date of Graduation: _____

Degree Earned: _____

Criminal Background

Have you ever been convicted or pled guilty to a felony or misdemeanor? ____

If yes, on a separate piece of paper, please give the date of the offense, the charge, the place the incident occurred, and the outcome.

Health Insurance Information

Wife's Insurance Provider: _____

Name of Company

Member Number

Telephone Number

Street Address

City

State

Zip

Husband's Insurance Provider: _____

Name of Company

Member Number

Telephone Number

Street Address

City

State

Zip

Description of Fertility Insurance Coverage

Do **either** of you have insurance covering **ANY** infertility Procedures (medication, diagnosis or treatment)? Please also attach summary of benefits related to fertility treatment from your insurance policy and history of benefits received from fertility related treatments. Attach a **photocopy** of both sides of your insurance card.

Does your insurance cover prenatal care? _____

Does your insurance coverage have a family plan? _____

Medical Information of Wife

(Please provide information regarding the physicians who have been treating you for fertility issues):

Physician's Name Telephone Number

Street Address

City State Zip

Diagnosis and Type of Treatment Received to Date

Physician's Name Telephone Number

Street Address

City State Zip

Diagnosis and Type of Treatment Received to Date

Attach an extra page if necessary

What was your diagnosis? Please check which of the following apply: endometriosis (surgically diagnosed) tubal disease male factor ovulation disorder (e.g., PCOS)

unexplained infertility other: _____

Type of Treatment Received to Date

Outcome (Did you or did you not achieve pregnancy? Did you miscarry?)

Physician's Name

Telephone Number

Clinic

Street Address

City

State

Zip

How many years have you been trying to conceive? _____

Have you ever been pregnant? Yes No If yes, how many times: _____

How many live births? _____ Miscarriages _____ Termination _____

Ectopic _____ Still Born _____

Name and address of clinic and physician that treated you:

Medical Information of Husband

Have you been diagnosed with infertility by an endocrinologist or other healthcare specialist? _____

If yes, what was your diagnosis?

Have you been under treatment for your diagnosis? _____

If yes, please list treatments and outcomes:

Personal References (Non-Relative)

1. _____
Name Telephone Number

Street Address

City State Zip

How do you know this person?

2. _____
Name Telephone Number

Street Address

City State Zip

How do you know this person?

ADDITIONAL INFORMATION TO BE SUBMITTED WITH THIS COMPLETED APPLICATION FORM

- You must meet the American Society for Reproductive Medicine definition of Infertility (i.e. blocked tubes, unexplained infertility, endometriosis, PCOS, male factor, female factor, etc). Infertility must be officially diagnosed by a fertility specialist. Please attach a letter from your treating fertility specialist explaining the medical reasons for pursuing fertility treatments and the likelihood of success. Please make sure to include the Medical Records Release form provided by Chance to Hope.
- Write a narrative on a separate page regarding the financial reasons for submittal of this application and how the grant money would be used. Include a description of any unusual financial circumstances that may affect our consideration of your application for financial assistance, complete the personal financial statement and make a copy of your most recent IRS tax return (at least two), pay stubs from both partners, and submit with your application.
- Write a narrative on a separate page answering the following questions: Why do you believe you are a prime candidate to receive a grant from Chance to Hope?

Amount of Funds Requested (amount potentially awarded will be at the discretion of our organization and based on the availability of funds):

\$ _____

MEDIA RELEASE FORM

While infertility is a very personal experience, part of our mission is to raise Fertility Awareness nationwide. By giving us your information (name, testimonial, photo), you are giving other couples hope while simultaneously educating communities about the success of treatments. Thank you for your full participation in our program.

_____ I/we grant permission to Chance to Hope and its subsidiaries and sponsors to use my/our name and/or photographs or video media in printed or electronic matter for use in publication and marketing materials. I/we further authorize the above entities to use my/ our name(s) and/or photographs or video media, or printed or electronic matter on its website or other electronic forms of media ("marketing materials").

_____ I/we commit to participate in all future requests from Chance to Hope for any and all television appearances and other media forums including but not limited to newspapers and editorials for use in publication and marketing materials for up to five (5) years from the date the grant was awarded.

_____ I /we hereby waive any right to inspect or approve the finished photographs or video media in printed or electronic matter that may be used now or in the future, whether that use is known to me/us or unknown, and I/we waive any right to royalties or other compensation arising from or related to the use of the photographs or video media in printed or electronic marketing materials.

_____ I/we hereby agree to release, defend and hold harmless Chance to Hope and its subsidiaries, including any firm publishing and/or distributing the finished product in whole or in part, whether on paper or via electronic media, from and against any claims, damages or liability arising from or related to the use of the photographs or video media in marketing materials.

_____ I/we have read this release before signing below and fully understand the contents, meaning and impact of this release. I/we understand that I/we have had an opportunity to address any specific questions regarding this release by submitting those questions to Chance to Hope in writing prior to signing, and/or by consulting a professional of my own choosing and I/we agree that my/our failure to do so will be interpreted as free and knowledgeable acceptance of the terms of this release.

Date: _____

Husband's Name: (Please print) _____

Husband's Signature: _____

Wife's Name: (Please print) _____

Wife's Signature: _____

RELEASE OF
EMPLOYMENT AND PERSONAL INFORMATION

We, _____, give permission to

Current Employer/Educational/Personal Reference

To verify our employment and educational information and to respond to requests of information from any agent of *Chance to Hope*, in connection with our application for financial assistance from the *Chance to Hope Grant* program.

Employee Signature (Husband)

Date

Printed Name (Husband)

Phone Number

Employee Signature (Wife)

Date

Printed Name (Wife)

Phone Number

MEDICAL RECORDS AND INFORMATION RELEASE

We, _____, give permission to

Name of Physician or Medical Facility

To send copies of our medical records or to respond to requests of information from any agent of Chance to Hope, in connection with our application for financial assistance from the *Chance to Hope Grant* program, designed to help financially needy married couples with the monetary burden of fertility assistance.

THE INFORMATION TO BE RELEASED includes, but is not limited to, the following:

Medical Summary

Treatment Planning

Patient Signature

Date

Printed Name

Phone Number

Patient Signature

Date

Printed Name

Phone Number

INFORMED CONSENT AND ACKNOWLEDGMENT OF RISK

IN CONSIDERATION for the opportunity to apply for participation in the Chance to Hope program, the undersigned applicant and her/his spouse understand and agree that:

1. There is significant risk in undergoing fertility treatment including but not limited to: irritation, discomfort and bruising of the arm related to taking injections; discomfort and possible side effects from taking "fertility drugs" including but not limited to the over stimulation of the ovary which may require hospitalization and medical therapy; discomfort and the possibility of infection or injury to abdominal organs or blood vessels during the egg retrieval process; the chance of multiple pregnancy (e.g., twins, or triplets) due to the implantation of multiple embryos; and the chance of fetal and/or newborn malformations (although IVF-ET is not considered to increase the risk of fetal and/or newborn malformations any higher than such risk is with normal conception);

2. They assume all risk of and financial responsibility for any loss or injury related directly or indirectly to participation in the program and agree to indemnify and hold Chance to Hope harmless from and against any and all costs, claims, demands, charges, liabilities, obligations, judgments, executions, costs of suit and actual attorneys' fees incurred or suffered by the applicant as a result of, or arising out of, the applicant's participation in the Chance to Hope program except for claims resulting wholly from the gross negligence of Chance to Hope;

3. Chance to Hope itself is not a medical expert or provider of any medical services and makes no determination as to whether this program is advisable or appropriate for anyone; participation in this program is voluntary and participants in the program agree to evaluate the risks of participating in the program independently and with the aid of their personal medical professionals to determine if the program is appropriate for them, their families and their medical and personal needs;

4. All aspects of the program including without limitation the services donated, the criteria for participation, the application and review process and the methods used to publicize the program are subject to change at anytime, without notice, in Chance to Hope's sole discretion based on the availability of donated services, funding and the best interests of Chance to Hope and the public;

5. The physicians, clinics and other donating medical services for this program may require additional consents and releases prior to allowing applicants selected by Chance to Hope to participate in the program and receive medical treatment; and,

6. The laws of the Indiana shall govern this Agreement and any dispute arising under this agreement.

This Informed Consent and Acknowledgement of Risk may not be amended, supplemented or abrogated without the written consent of Chance to Hope

The undersigned applicant and her/his partner have read and understand the content of this Informed Consent and Acknowledgement of Risk and execute this agreement freely and voluntarily.

Husband's signature

Date

Wife's signature

Date

NOTORIZATION OF Chance to Hope, INFORMED CONSENT AND ACKNOWLEDGMENT OF RISK FORM

STATE OF _____

CITY/COUNTY _____

I HEREBY CERTIFY, that on this _____ day of _____, 20____, before me, a Notary Public in and for the jurisdiction written above, personally appeared _____ and _____, being well known to me (or satisfactory proven) to be the persons who signed this Informed Consent and Acknowledgement of Risk agreement, and acknowledged that they executed the agreement as their free and voluntary act and deed for the purposes specified in the agreement.

Notary Public

My commission expires:

CERTIFICATION

We swear under oath that the information provided in this application and required attachments is truthful and accurate. We give Chance to Hope permission to contact any individual or professional referenced in the application and required attachments to verify the submitted information. We acknowledge receipt of the Informed Consent and Acknowledgement of Risk form.

Husband's Signature

Date

Wife's Signature

Date

NOTORIZATION OF Chance to Hope, CONFIDENTIAL APPLICATION

STATE OF _____

CITY/COUNTY _____

I HEREBY CERTIFY, that on this _____ day of _____, 20____, before me, a Notary Public in and for the jurisdiction written above, personally appeared _____ and _____, being well known to me (or satisfactory proven) to be the persons who signed this Confidential Application, and acknowledged that they executed the agreement as their free and voluntary act and deed for the purposes specified in the agreement.

Notary Public

My commission expires:

Selection is based on the compelling nature of an applicant's circumstances, their fertility history, financial situation and a number of other determining factors.

Please return this completed application along with the required attachments to:

Chance to Hope
818 N. Boeke Rd.
Evansville, Indiana 47711

You will be notified in writing if you are selected as a grant recipient. Thank you for your time and interest in our grant program.