BABY QUEST - GRANT APPLICATION - APPLICATION DEADLINE: NOV 15, 2017

Send to:
Baby Quest Foundation, Inc.
149 S. Barrington Ave. #112
Los Angeles, CA 90049

_____ I am a 1st time applicant
_____ 2ND time applicant ______ 3rd time applicant
All applications MUST contain a non-refundable $50 fee.

Please tell us how you heard about Baby Quest: ________________________________

PERSONAL INFORMATION

Name of Applicant: ____

Applicant's Partner (if applicable): ____

Home address: ____

____

Age: ____________________ ___________________________
Applicant Partner

E-mail address: _____________________________________

Re-write e-mail IN CAPS: _______________________________
(Print clearly or we cannot contact you.)

Phone: _______________________ (day) ________________________ (evening)

Age(s) of children in household (if any): _____________________________

Procedure needed: ___________________ LIST COSTS AS QUOTED. DO **NOT** ATTACH CLINIC COST SHEETS

Cost breakdown: physician _______________

lab fees ________________

anesthesia: ________________

facility: ________________

Other: ___________________ (i.e. egg donor fees, surrogacy fees if applicable)

TOTAL: ________________

Cost of medications: ___________________ (This should NOT be included in the above total.)

If selected, what amount could you contribute? ________________________

EMPLOYMENT HISTORY (Please provide information for past 5 years)

Applicant's Current Employer ____

Employer's Contact Information ____

Job Title ______________________________ Work phone ____________________

Annual salary ______________________________Dates of employment ____________

Applicant's Previous Employer ____

Employer's Contact Information ____

Job Title ______________________________ Work phone ____________________

Annual salary ______________________________ Dates of employment ____________

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Partner's Current Employer ____

Employer's Contact Information ____

Job Title ______________________________ Work phone ____________________

Annual salary ____________________________ Dates of employment ____________

Partner's Previous Employer ____

Employer's Contact Information ____

Job Title ______________________________ Work phone ____________________

Annual salary ____________________________ Dates of employment ____________

EDUCATION

Applicant's Education/Profession ____

Last School Attended _________________________ Date of Graduation ______________

Highest Degree Earned ________________________

Partner's Education/Profession ____

Last School Attended _________________________ Date of Graduation ______________

Highest Degree Earned ________________________

CRIMINAL BACKGROUND

(Grant finalists will be asked to submit to a complete background check at their expense. Cost is generally $250.)

Have you (or your partner if applicable) been convicted of a felony or misdemeanor? If so, please provide details.

____

____

HEALTH INSURANCE INFORMATION

Applicant's Insurance Provider ____

Member Number __________________ Phone Number ___________________________

Do you have Prenatal Coverage? ______ Do you have Coverage for Dependents? ___________

Partner's Insurance Provider ____

Member Number __________________ Phone Number ___________________________

Do you have Prenatal Coverage? _________________

Do you have Coverage for Dependents? ____________

Does either the applicant or partner have insurance that covers any infertility procedures (including medication, diagnosis, and/or treatment)? _____ If so, describe your coverage in detail.

____

____

If your insurance covers any type of infertility treatment, what benefits have you received up to this point?____

____

____

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.)

____

____

____

GENERAL MEDICAL INFORMATION

Have you or your partner ever been diagnosed with any of the following?

___cancer ___hepatitis ___HIV ____diabetes ____heart disease ____other

If so, please explain in detail ____

____

Have you or your partner ever been diagnosed with any of the following?

___depression ___bipolar disorder ___ personality disorder ___ other mental condition

If so, please explain in detail ____

What medications do you currently take? _____________ (applicant) ______________(partner)

FINANCIAL INFORMATION

Total monthly household income before taxes: ________________

1. Monthly income from salary, wages _________________
2. Self-Employment Income ___________________
3. Income from overtime, commissions, tips, bonuses, etc. _____________________
4. Dividends, interest _________________
5. Income from trusts or annuities _____________
6. Pensions and retirement funds _____________
7. Social Security income _________________________
8. Disability, unemployment insurance or worker's compensation _________________
9. Public Assistance (welfare) _______________________
10. Income producing property _________________

List ALL Joint and Individual Assets:

1. List all property owned including property location(s) and fair market value of each.

   ____

   ____

2. List pension fund values ____________________ (IRA, Pension, Profit-sharing, etc.)
3. Life insurance present cash value _______________
4. Savings account(s) balance ____________________
5. Money market accounts and CD values __________
6. Motor vehicles (year, make, model, approximate Blue Book Value)

   ____

7. List all liabilities (mortgage, credit cards, loans, creditors, etc.) Include amounts owed.

   ____

   ____

8. Are you or have you ever been in collection? _________________________

FERTILITY HISTORY

(Please note: This is IN ADDITION to the personal story you are asked to submit.)

In the space below, please relate your fertility struggles. Include past procedures, if you've changed clinics at any time, how much money you've spent on treatment, the outcome, your plans to pursue ivf, surrogacy, etc. This is strictly an account of your MEDICAL issues trying to conceive. MUST FIT ON THIS PAGE. You MUST also submit the personal story …item #1 on the check list below.

SUBMISSIONS CHECK LIST:

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

1. A personal story (maximum 2 pages) Do NOT document your fertility history here. We want to know who you are – hobbies, profession, family history, why you would be a worthy candidate. Be as creative as you would like. We encourage photos. Please limit this to 2 photos.
2. An account of your fertility history (see page 6)
3. A copy of both sides of applicant's insurance card and that of a partner (if applicable.)
4. Application fee of $50. Make check payable to Baby Quest Foundation.
   We do NOT accept money orders. Personal Check or Cashier's Check only. Applications submitted without a fee will NOT be reviewed.
5. Signed release form (see below)
6. Medical packet: Your physician MUST complete the medical portion of the application (pages 10,11,12). It is the applicant's responsibility to obtain these pages from the physician and include them with the application.
7. Mailing hints: Please avoid a last minute rush and submit your application as early as possible. DO NOT SEND YOUR SUBMISSION WITH A SIGNATURE REQUIRED. WE OFTEN PICK UP MAIL AFTER HOURS WHEN WINDOWS ARE CLOSED. THIS WILL DELAY RECEIPT.
8. 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 (pages 9-11).
9. List costs as quoted to you. DO NOT INCLUDE CLINIC COST SHEETS SINCE THEY OFTEN INCLUDE PROCEDURES NOT RELATED TO YOUR CONDITION.
10. WE DO NOT ACCEPT APPLICATIONS SUBMITTED VIA FAX OR EMAIL.
11. Scrapbooks, posters, creative photo books are unnecessary. We do NOT return submissions.
12. PLEASE FOLLOW THE ABOVE GUIDELINES. SEND ONLY WHAT IS REQUIRED. DO NOT INCLUDE PAGES OF MEDICAL HISTORY, ETC.

Baby Quest receives hundreds of applications each cycle. We are limited by the amount of funds that are donated. We strive to be diverse in regards to ethnicity, sexual orientation, and geography. Please know that we CANNOT fund all those who apply, even though we would like to.

The following form allows Baby Quest to use excerpts from your personal statement No last names will be used without permission.

RELEASE FORM

The Applicant hereby assigns and grants the Organization 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 Organization 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 Organization and Applicant shall defend and indemnify the Organization from and against any claims that any of Applicant's friends, family or other persons mentioned in the personal statement may assert against the Organization 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 Organization. Surnames will NOT be used so as to protect the identification of any of the above.

____________________________________ __________________________

Applicant's Signature Date

____

Applicant: Print Name

____________________________________ __________________________

Partner's Signature Date

____

Partner: Print Name

I give my permission for Baby Quest to contact my physician and/or clinic's business manager.

_______________________ _________________________ _______________

Applicant Partner Date

All information submitted to Baby Quest will be held in strictest confidence and viewed only by the selection committee. We thank you for your interest in Baby Quest and wish each and every one of you the best in your attempt to build a 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 Baby Quest Foundation, Inc.

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 Baby Quest Foundation.

Clinic name: ____

Address: ____

____

Physician: ____

Patient's Signature: __________________________________ Date: _______________

Print Patient's Name: _________________________________

Signature of Spouse/Partner (if applicable) : __________________________ Date: _________

Print Name: ____

MEDICAL EVALUATION (**To be completed by the physician.**)

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 (circle all that apply): Male tubal/uterine ovarian unexplained pregnancy loss

Prior treatments: Number of IUI's __________________ Outcome ____________________

Number of IVF's __________________ Outcome ______________________

# of eggs ___________ # fertilized _________ # transferred _______ # in storage _________

Date of last procedure: ___________ Patient currently undergoing treatment: ____yes ____ no If yes, please explain:

____

Female Evaluation

Medical problems ____

Current medications ______________________________ Surgical history _______________________

Ovarian reserve: Day 3 FSH/E2 __________ AMH _______ Antral Follicle count __________

Tubal/Uterine

HSG result ____ (date: ___________)

Hydrosonogram ____ (date: ___________)

Hysteroscopy ____ (date: ___________)

Male work-up: Semen analysis (dates)__________

Volume ____________________ (ml) Sperm concentration ____________)Million/ml)

Motility ________________ Normal morphology _____________________ (indicate WHO or Kruger strict criteria)

MEDICAL EVALUATION (CONTINUED)

What is your recommendation for treatment for this patient? ___________________________

____

____

Type of medications and dose you plan to use: ____

____

____

Total cost EXCLUDING MEDS____________________________ (not including any discounts)
(See next page to enter discount availability.)

Physician cost ______________ Lab fees ____________ Anesthesia __________ Facility fee _________

Other __________ Includes ICSI? _____yes _____ no Cryopreservation? _____yes _____no

Approximate medication cost: ____________Portion (if any) to be covered by insurance? ______________

Baby Quest strives to cover some of the medications WHEN POSSIBLE. We would ask that you prescribe the most efficient protocol while keeping price in mind as well. Thanks!

THIS FORM HAS BEEN COMPLETED BY:

Physician ____

Clinic ____

Address ____

____

Phone _______________________ Email ____________________ Fax ___________________

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

_____________________________________ _________________________
Physician Date

Patient's Name: ______________________________

Physician: ___________________________________

Clinic: ______________________________________

Dear Physician,

You have been given the enclosed medical form because your patient is applying for a Baby Quest grant.

Baby Quest Foundation is a 501 c (3) charity founded in 2011. 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, and gestational surrogacy. In three years, we have awarded 46 grants and have seen the birth of 16 babies with 8 more expected in the coming months and other recipients soon to undergo procedures.

Baby Quest'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 Baby Quest recipient.**

- ☐ Our clinic would be willing to offer the grantee a $_______ grant.
- ☐ Our clinic would match the Baby Quest Foundation grant up to a maximum of $______.
- ☐ Our clinic would offer a grant of _____ % of 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 Baby Quest has questions about financial details for this patient, who should be contacted?

First name: __________________ Last name: _____________________

Department at clinic: _________________________

Phone: _________________ Extension: _______ Email: _________________________________

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

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

Cordially,
Pamela Hirsch
Founder, Baby Quest Foundation
323-206-6088