

**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 1<sup>st</sup> time applicant  
\_\_\_\_\_ 2<sup>ND</sup> time applicant \_\_\_\_\_ 3<sup>rd</sup> 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.

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**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.

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

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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.)

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### **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 \_\_\_\_\_

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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.

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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)

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

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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](http://www.babyquestfoundation.org)) has information on our process and recent success stories. Thank you.

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