BABY QUEST - GRANT APPLICATION - APPLICATION DEADLINE: NOVEMBER 14, 2018

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.
Applications MUST BE IN OUR HANDS BY NOV. 14TH!!

****Before submitting, please see the checklist on page 8.**

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 or surrogacy fees, genetic test, etc)
Explain on page 2.

TOTAL: _____

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

If selected, what amount could you contribute? _____

EXPLANATION OF OTHER EXPENSES:

If, on the previous page, you indicated OTHER expenses, please explain.

1. Are you doing genetic testing of any type such as CCS, PGS, PGD? _____Yes _____ NO
   Which tests? _____ Cost? _____

2. Are you using an egg donor? _____ Yes _____ No Total cost: _____
   If yes, please answer the following questions:
   Is this donor contracted through an agency or is it a friend/relative? _____
   If through an agency, please name _____
   Are you doing a fresh or frozen transfer? _____
   Please itemize the associated costs of your egg donation:
   _____ _____
   _____ _____
   When do you anticipate being ready for embryo implantation? _____

   Additional notes:

3. Are you using a surrogate to carry? _____ Yes _____ No Total cost: _____
   If yes, please answer the following questions:
   Are you using a "known" surrogate or someone hired through an agency? If agency, please name _____
   Please indicate the cost of each item if applicable:
   Medical clearance for surrogate _____ Psych evaluation _____
   Insurance for surrogate _____ Legal for surrogate and IP _____
   Agency fee _____ Surrogate compensation _____
   Clinic fees for transfer _____ Medication costs _____

   Additional notes:

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 _____

****

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, you will be relating your fertility history by answering the following questions. You will also be able to provide additional details.
Please write legibly or preferably type.

1. List any procedures you have had such as medications to stimulate, iui, ivf, etc. List dates, number of eggs produced, results.

2. How much money have you spent on past procedures? Please itemize by procedure. Are you still paying for this treatment? ____yes ____ no

3. What is your "clinic" history? Have you sought a second opinion, changed clinics, etc? Please explain.

4. Please add any additional fertility information you feel is relevant.

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, 13). 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.
13. YOU MUST CLICK THE FOLLOWING LINK TO TELL US HOW YOU HEARD ABOUT BABY QUEST: https://www.surveymonkey.com/r/TMBFYK2

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

BABY QUEST DOES NOT PAY FOR CRYOPRESERVATION. PLEASE DO NOT INCLUDE IN COST.

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 **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