BABY QUEST – TREATMENT RESUMPTION GRANT APPLICATION

SUBMISSION CHECK LIST:

1. **Deadline:** Applications for Resumption Grants must be received by Baby Quest by **August 1, 2020.** Late submissions will not be accepted. Note that submissions must be mailed - electronic submissions will not be considered.

   Send your application to:
   
   *Baby Quest Foundation; 149 S. Barrington Ave. #112, Los Angeles, CA 90049*

   We strongly suggest that you retain a copy of your submission for your records and keep a record of your tracking number.

2. **Photos:** Please include 1-2 photos of yourself and/or your family. These will be used for raising awareness and donations to help others in need.

   *Baby Quest receives hundreds of applications each year. 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.*
### SECTION #1: PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Applicant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant’s Partner (if applicable):</td>
</tr>
<tr>
<td>Home address: (street address, city, state, zip code)</td>
</tr>
<tr>
<td>Applicant’s age:</td>
</tr>
<tr>
<td>Email address:</td>
</tr>
<tr>
<td>Re-enter email address (Print in capital letters):</td>
</tr>
<tr>
<td>Daytime phone:</td>
</tr>
<tr>
<td>Procedure cancelled:</td>
</tr>
<tr>
<td>If IVF, what number cycle: 1st 2nd 3rd 4th</td>
</tr>
</tbody>
</table>

### SECTION #2: FINANCIAL FERTILITY HISTORY

What procedures have you had in the past leading up to the cancelled cycle:

How did you pay for the cancelled cycle? Loan Savings Insurance – percentage covered: %

How much did you spend on:

- The cancelled cycle? $ 
- Medications for the cancelled cycle? $ 
- Clinic/anesthesia/lab (include genetic testing if applicable): $ 

What are the costs to resume the cancelled cycle?

- Medications: $ 
- Clinic fees: $ 

Which specific medications need re-purchasing?

What quantities are needed of each?

Are your medication costs covered by insurance? Yes No Partial – amount covered:

What is your approximate out-of-pocket cost to re-purchase? $ 

How much in clinic fees are you being charged to resume? $ 

What do these fees cover?

When do you anticipate resumption of treatment?
SECTION #3: FINANCIAL INFORMATION - INCOME

Total monthly household income **before** taxes: $____________

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Monthly income: salary, wages</td>
<td>$</td>
</tr>
<tr>
<td>b. Self-Employment Income</td>
<td>$</td>
</tr>
<tr>
<td>c. Overtime, commissions, tips, bonuses, etc.</td>
<td>$</td>
</tr>
<tr>
<td>d. Dividends, interest</td>
<td>$</td>
</tr>
<tr>
<td>e. Income from trusts or annuities</td>
<td>$</td>
</tr>
<tr>
<td>f. Pensions, retirement funds</td>
<td>$</td>
</tr>
<tr>
<td>g. Social Security income</td>
<td>$</td>
</tr>
<tr>
<td>h. Disability, unemployment insurance or worker’s compensation</td>
<td>$</td>
</tr>
<tr>
<td>i. Public Assistance (welfare)</td>
<td>$</td>
</tr>
<tr>
<td>j. Income producing property</td>
<td>$</td>
</tr>
</tbody>
</table>
Personal Statement Release Form

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

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: print name    Applicant: signature    Date

_______________________________ ______________________________  ____________
Partner: print name    Partner: signature    Date

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.
Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize the clinic named below to disclose certain protected health 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.

<table>
<thead>
<tr>
<th>Clinic name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Physician:</td>
</tr>
</tbody>
</table>

_______________________________   __________________________  ____________
Applicant: print name          Applicant: signature          Date

_______________________________   __________________________  ____________
Partner (if applicable): print name  Partner (if applicable): signature  Date
Physician’s Statement

Physician: _____________________________  Clinic: _______________________________

Email: ________________________________  Patient’s Name: _______________________

Dear Physician,

Your patient has applied for a grant toward resumption of fertility treatment that was interrupted by the COVID-19 outbreak.

Baby Quest Foundation is a 501c (3) charity founded in 2011. Our mission is to grant financial assistance to those struggling with the high costs of infertility treatments such as in vitro fertilization, egg and sperm donation, embryo donation, and gestational surrogacy. As of March 1st, 2020, we have awarded over 117 grants and have seen the birth of 88 babies with 16 more expected in the coming months. You can learn more about our foundation at babyquestfoundation.org.

Please confirm the following:

☐ The above-named patient had fertility treatment interrupted on _____ /____ /2020

☐ Resumption of treatment will incur fees of (do not include medication costs):

  Physician fee: $__________________

  Lab fee: $_______________________

  Anesthesia fee: $_________________

  Other: $_________________

Please join the many clinics offering our recipients financial help.

☐ Our clinic will be willing to offer the patient a discount of ________________.

This form has been completed by:

First name: _________________  Last name: _______________  Dept at clinic: _________________

Phone: ________________  Extension: ______  Email: ________________________________

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