# KEEPING HOPE ALIVE

## Application for Infertility Grant

## Deadline for Submission: Wednesday May 15th, 2019

***Please type or clearly print***

Female Name: _____ Male Name:_____

Home Phone Number: _____
Alternate Phone #1: _____
Alternate Phone #2: _____
Mailing Address: _____
Email address: _____

How much money are you requesting? (cannot exceed $10,000) $_____
What is the name of your clinic? _____
Who is your doctor (fertility clinic)? _____
What is the address of your clinic? _____
What is the phone number of your clinic?_____

| | Female | Male |
|---|---|---|
| State of Residency *(Must be NJ or PA)* | | |
| DOB (female must be under 40 yrs old at application) | | |
| US Citizen or Legal Permanent Resident Alien | | |
| Email Address | | |
| Current Job Title | | |
| Employer's Name | | |
| Dates of Employment | | |
| How did you hear about KHA Grant? | | |
| If married, number of years? | | |
| Do you have any biological children? | | |
| Have you ever been arrested? | | |

Does either applicant have insurance/employer sponsored support that will assist with the costs associated with fertility treatment? ____ YES ____ NO ____ INCOMPLETE COVERAGE
*If incomplete coverage, please describe what is covered and what is not covered:*

_____

_____

Are you willing to volunteer at future KHA sponsored events? ___ YES ___ NO

**Personal Statement:** Please submit a written (may be typed) statement indicating the potential importance of this grant for your family and why you are applying for this grant. Please include any extenuating life circumstances (examples: job loss, financial struggle, life changes, etc.) that should be considered by the committee as they review your application for the KHA Infertility Grant. **Please limit length to this page only.**

**Statement:**

**We attest that we wrote this statement (Signatures) _____ Date:_____**

**Annual Household Income** (Including combined adjusted gross income. This should match Line 37 from IRS Form 1040 plus other annual revenue of Applicants): $ _____

**PLEASE UPLOAD AND ATTACH PAGES 1 & 2 ONLY OF YOUR 2018 SIGNED FEDERAL FORM 1040. IF 2018 FEDERAL RETURNS ARE NOT COMPLETED PLEASE UPLOAD 2017 FORM 1040 ALONG WITH 2018 W2 STATEMENTS.**

**Household Budget**: Please complete the chart below to provide your family's monthly budget for a typical month.

| **Expense** | **Average Cost/monthly** |
|---|---|
| Mortgage/Rent(s) | $ |
| Car Payment(s) | $ |
| Utilities | $ |
| Credit Cards | $ |
| Alimony/Patrimony | $ |
| Education Loans | $ |
| Other: | $ |
| Other: | $ |
| Other: | $ |
| **Total Monthly Expenses** | $ |

**Savings:**

What is your current total balance of savings and checking accounts?

Bank Name: _____ Savings: $_____ Checking: $ _____
Bank Name: _____ Savings: $_____ Checking: $ _____
Bank Name: _____ Savings: $_____ Checking: $ _____
Bank Name: _____ Savings: $_____ Checking: $ _____

What is the combined net worth of your retirement/IRA savings plans? $_____

Do you own any stocks or bonds or have any other investments? If yes, please indicate the total portfolio value: $_____

What will the grant funds be used for and how do you plan to allot the funds? Please list a proposed budget:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

## Medical History for Female Applicant:

Seeking grant for infertility treatment for the following (check the appropriate): ____ IVF ____ IUI ____ FET

Age: _____ Height: _____ Weight: _____

Medical Problems:

_____
_____
_____
_____

Have you been told you have infertility? ____ YES ____ NO
Cause: _____

Surgical History:

_____
_____
_____

Current Medications:

_____
_____
_____

Do you smoke? ____ YES ____ NO If yes, how often/packs a day? _____

Have you ever used marijuana or used other illicit drugs? (please specify) _____

If "YES" – when was last drug use? _____

What procedures and treatments has patient already undergone and at what cost?

| Procedure/Date | Out of Pocket Costs | Amount Covered by Insurance |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Any other pertinent medical information you would like to share:

_____
_____
_____
_____
_____

## Medical History for Male Applicant:

Seeking grant for infertility treatment for the following (check the appropriate): ____ IVF ____ IUI ____ FET

Age: _____ Height: _____ Weight: _____

Medical Problems:

_____
_____
_____
_____

Have you been told you have infertility? ____ YES ____ NO
Cause: _____

Surgical History:

_____
_____
_____

Current Medications:

_____
_____
_____

Do you smoke? ____ YES ____ NO If yes, how often/packs a day? _____

Have you ever used marijuana or used other illicit drugs? (please specify) _____

If "YES" – when was last drug use? _____

What procedures and treatments has patient already undergone and at what cost?

| Procedure/Date | Out of Pocket Costs | Amount Covered by Insurance |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Any other pertinent medical information you would like to share:

_____
_____
_____
_____
_____

## CONSENT

**By submitting this application and signing below, the applicant(s) understand and consent to the following (initial each statement and sign below):**

**1) To having our names and photographs published and released by Keeping Hope Alive Inc. and any/all press releases should we be awarded a grant. _____ (initial) _____ (initial)**

**2) Submitting this application does not in any way guarantee that we will receive a KHA Infertility Grant. _____ (initial) _____ (initial)**

**3) We will not receive any money directly; the grant award will be provided directly to the service providers (fertility clinic). _____ (initial) _____ (initial)**

**4) The grant reviewers will be receiving personal medical and financial information and this information will not be shared with anyone outside the selection committee. _____ (initial) _____ (initial)**

**5) If we are awarded a KHA Infertility Grant we understand that the monies received must be used within 12 months of receipt for the purpose requested and any unused monies will be returned to the KHA grant pool for future use. _____ (initial) _____ (initial)**

**6) Should a refund be available due to services costing less than anticipated, services not being rendered, the refund (up to the value of the grant amount) will be returned to the KHA Infertility Grant pool and that we (applicants) shall not be entitled to any direct compensation or refund. _____ (initial) _____ (initial)**

**7) If it is found that any information contained in this application was falsified, if instructions were not followed, or if your family, fertility, or legal status changed following the submission of this grant and KHA was not notified of such change, the grant money, if offered, may be rescinded or forfeited at the discretion of KHA Board. _____ (initial) _____ (initial)**

**8) KHA has the right to confirm that applicants are in good standing with their fertility clinic. _____ (initial) _____ (initial)**

**9) The information contained in this application is truthful. _____ (initial) _____ (initial)**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| **Female Signature** | **Printed Name** | **Date** |
| _____ | _____ | _____ |
| **Male Signature** | **Printed Name** | **Date** |

**PLEASE EMAIL COMPLETED APPLICATION WITH REQUIRED ATTACHMENTS TO**
**KEEPINGHOPEIVF@GMAIL.COM**

**$50 application fee can be made payable via cash/check: Keeping Hope Alive Inc. & mailed to Attn: Keeping Hope Alive 360 Staggerbush Rd. Williamstown, NJ 08094**

**May also pay via PayPal: Keepinghopeivf@gmail.com**