

BABY QUEST - GRANT APPLICATION

SUBMISSION CHECK LIST:

1. **Deadline:** Applications must be received by Baby Quest by the deadline date. No late submissions accepted.

To avoid a last minute rush, please submit your application as early as possible. Do not send your submission with a "Signature Required" as this will delay receipt, since we often pick up mail after hours when windows are closed.

Please send your application form along with application fee and all other requested documentation to:

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

Note that we do not accept applications submitted via fax or email. We strongly suggest that you retain a copy of your submission for your records and keep a record of your tracking number.

2. **Personal story:** 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. Include 1-2 photos.
3. **Insurance:** A copy of both sides of applicant's insurance card and that of a partner (if applicable.)
4. **Fee:** 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. **Application form:** The entire application form herein, including release form and medical packet. Your physician MUST complete the medical portion of the application. It is the applicant's responsibility to obtain these pages from the physician. Note that fertility clinics and physicians often require weeks to complete the medical form.
6. **Do not submit:** Medical history documentation or any other documents not explicitly requested. We do NOT return submissions.

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.

SECTION #1: PERSONAL INFORMATION

Name of Applicant:

Applicant's Partner (if applicable):

Home address: (street address, city, state, zip code)

Applicant's age:

Partner's age:

Age(s) of children (if any):

Email address:

Military service (applicant or partner): explain

Re-enter email address (Print in capital letters):

Daytime phone:

Evening phone:

I am a:

 1st time applicant 2nd time applicant 3rd time applicant**SECTION #2: REQUESTED GRANT AMOUNT**

Procedure needed:

Cost breakdown (do not attach clinic cost sheets):

Physician: \$ _____ Anesthesia: \$ _____ Other*: \$ _____

Lab fees: \$ _____ Facility: \$ _____

TOTAL (excluding medication): \$ _____

Cost of medications: \$ _____

If selected, what amount would you be able to contribute? \$ _____

* "Other" expenses can include egg donor or surrogacy fees, genetic testing, etc. You will be asked to detail these procedures and fees in the next section.

SECTION #3: EXPLANATION OF "OTHER EXPENSES"

1. Genetic testing:

Are you doing genetic testing of any type, eg. CCS, PGS, PGD? Yes No

Which tests? _____ Cost? \$ _____

2. Egg donation:

Are you using an egg donor? Yes No Total cost: \$ _____. If yes:

a) Is this donor contracted through an agency or is it a friend/relative? _____

b) If through an agency, please name _____

c) Are you doing a fresh or frozen transfer? _____

Please itemize the associated costs of egg donation (use separate sheet if necessary):

When do you anticipate being ready for embryo implantation? _____

3. Surrogacy

Are you using a surrogate to carry? Yes No Total cost: \$ _____.

a) If yes: are you using a "known" surrogate or one hired through an agency? If agency, please name: _____

b) Are you doing a fresh or frozen transfer? _____

Please indicate the cost of each item if applicable:

a. Medical clearance for surrogate	\$ _____	b. Psych evaluation	\$ _____
c. Insurance for surrogate	\$ _____	d. Legal for surrogate and IP	\$ _____
e. Agency fee	\$ _____	f. Surrogate compensation	\$ _____
g. Clinic fees for transfer	\$ _____	h. Medication costs	\$ _____

Note: If using a surrogate, the medical evaluation form must be completed for the surrogate. If the surrogate is provided by an agency, the agency must provide proof of medical clearance.

SECTION #4: EMPLOYMENT HISTORY (for previous five years)

APPLICANT:	Current employer, including contact information:	
	Job Title:	Work phone:
	Annual salary:	Dates of employment:
	Previous employer, including contact information:	
	Job Title:	Work phone:
	Annual salary:	Dates of employment:
PARTNER:	Partner's current employer, including contact information:	
	Job Title:	Work phone:
	Annual salary:	Dates of employment:
	Partner's previous employer, including contact information:	
	Job Title:	Work phone:
	Annual salary:	Dates of employment:

SECTION #5: EDUCATION HISTORY

APPLICANT:	Applicant's Education/Profession:	
	Last School Attended:	Date of Graduation:
	Highest Degree Earned:	
PARTNER:	Applicant's Education/Profession:	
	Last School Attended:	Date of Graduation:
	Highest Degree Earned:	

SECTION #6: 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:

SECTION #7: FINANCIAL INFORMATION - INCOME

Total monthly household income before taxes: \$ _____

a. Monthly income: salary, wages	\$	b. Self-Employment Income	\$
c. Overtime, commissions, tips, bonuses, etc.	\$	d. Dividends, interest	\$
e. Income from trusts or annuities	\$	f. Pensions, retirement funds	\$
g. Social Security income	\$	h. Disability, unemployment insurance or worker's compensation	\$
i. Public Assistance (welfare)	\$	j. Income producing property	\$

SECTION #8: FINANCIAL INFORMATION - 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? Yes No

SECTION #9: HEALTH INSURANCE INFORMATION

APPLICANT:

Applicant's Insurance Provider:

Member Number:

Phone Number:

Do you have Prenatal Coverage? Yes NoDo you have Coverage for Dependents? Yes No**PARTNER:**

Partner's Insurance Provider:

Member Number:

Phone Number:

Do you have Prenatal Coverage? Yes NoDo you have Coverage for Dependents? Yes No

Does either the applicant or partner have insurance that covers any infertility procedures (including medication, diagnosis, and/or treatment)? Yes No

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? Please include specific dollar amount.

SECTION #10: GENERAL MEDICAL INFORMATION

Have you or your partner ever been diagnosed with any of the following? (check all that apply)

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? (check all that apply)

Depression Bipolar disorder Personality disorder Other mental condition

If so, please explain in detail:

Applicant: what medications do you currently take?

Partner: what medications do you currently take?

SECTION #11: INFERTILITY HISTORY

Note: This section is IN ADDITION to the personal story you are asked to submit.

How long have you been attempting to conceive?

Have you ever been pregnant? Yes No

Result?

When? _____

List any procedures you have had such as medications to stimulate IUI, IVF, etc., itemized by procedure.

List dates, number of eggs produced and results. If needed, please submit on a separate sheet.

Total expenses for past procedures: \$ _____

Still paying for these procedures? Yes No

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

When do you anticipate starting your treatment?

(Note that Baby Quest does not reimburse for procedures already begun)

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.

Clinic name:
Address:
Physician:

Applicant: print name

Applicant: signature

Date

Partner (if applicable): print name

Partner (if applicable): signature

Date

MEDICAL EVALUATION (to be completed by the physician.)

Patient Information			
Patient Name:			
Height:	Weight:	BMI:	Age:
DOB:	Gravida:	Para:	Abortus:
Partner Age:		Does either partner smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Length of infertility (months trying):			
Cause of infertility (check all that apply): <input type="checkbox"/> Male tubal/uterine <input type="checkbox"/> Ovarian <input type="checkbox"/> Unexplained <input type="checkbox"/> Pregnancy loss			
Prior Treatments			
Number of IUIs:	Outcome: ____ eggs, ____ fertilized, ____ transferred, ____ in storage		
Number of IVFs	Outcome: ____ eggs, ____ fertilized, ____ transferred, ____ in storage		
Date of last procedure:		Patient currently in treatment: <input type="checkbox"/> Yes <input type="checkbox"/> 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:	
Hydrosogram:		Date:	
Hysteroscopy		Date:	

Male Semen Analysis:		
Volume (ml):	Sperm concentration (million/ml):	Motility:
Normal morphology (WHO or Kruger strict criteria):		
Treatment Plan		
Recommended treatment for patient?		
Type of medications and dose you plan to use:		
Total cost excluding meds (excluding discounts; enter discount availability on next page): \$_____		
<i>Note that Baby Quest DOES NOT pay for cryopreservation. Please do not include in cost.</i>		
Physician cost: \$_____	Lab fees: \$_____	Anesthesia: \$_____
Facility fee: \$_____	Other: \$_____	Includes ICSI? <input type="checkbox"/> Yes <input type="checkbox"/> No
Approximate medication cost: \$_____		
<i>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.</i>		
Portion (if any) to be covered by insurance: \$_____		

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

Letter to Physician

Physician: _____

Clinic: _____

Email: _____

Patient's Name: _____

Dear Physician,

Your patient is applying for a Baby Quest grant and your help is needed.

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 in vitro fertilization, egg and sperm donation, embryo donation, and gestational surrogacy. As of fall 2019, we have awarded over 100 grants and have seen the birth of 78 babies with 9 more expected in the coming months.

Please join the many clinics offering Baby Quest recipients financial help such as a 20% discount on services. **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 discount.

If Baby Quest has questions about financial details for this patient, who should be contacted?

First name: _____ Last name: _____ Dept at clinic: _____

Phone: _____ Extension: _____ Email: _____

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. If you have additional questions, feel free to contact me or visit our website (www.babyquestfoundation.org) for information and recent success stories.

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

PLEASE TELL US HOW YOU HEARD ABOUT BABY QUEST:

(Check all that apply)

Google Search: which keywords did you use to find us?

Social Media: Facebook Instagram Twitter Other: _____

Other media sources:

TV segment: please specify _____

Magazine article: please specify _____

Other: please specify _____

Family and friends

Fertility Clinic: which? _____

Other: _____

Please help us by liking baby quest on Facebook and following us on Instagram and Twitter!