2017 PARENTAL HOPE FAMILY GRANT APPLICATION

IVF - Parental Hope Family Grant Overview

The Parental Hope Family Grant ("Grant") covers the full cost of one egg retrieval, one embryo transfer (frozen or fresh), intracytoplasmic sperm injection (if medically necessary), and IVF education day fee. The Grant does not provide funds to cover the cost of embryo freezing, IVF consultation fee, and the cost of medication. Factors that the Board of Directors will consider when awarding a Grant shall include, but shall not be limited to, the Applicant's and Co-Applicant's financial situation, their Infertility Medical Diagnosis, video essay, and other relevant factors.

Eligibility Requirements

- Applicant (or Co-Applicant) must have one of the following:
  - A medical diagnosis of infertility by a Reproductive Endocrinologist according to the American Society for Reproductive Medicine's definition of Infertility; or
  - Be a carrier of a genetic disease or chromosomal disorder that requires the use of Assisted Reproductive Technology ("ART") services for healthy offspring; or
  - A Reproductive Endocrinologist has recommended ART services due to recurrent pregnancy loss.
- Applicant (and Co-Applicant) must be citizens of the United States.
- Applicant (and Co-Applicant) may have insurance that covers infertility treatments, including, but not limited to, IVF. While insurance coverage will not render Applicant (and Co-Applicant) ineligible, it will be factored into determining the financial need of Applicant (and Co-Applicant).
- All Applicants must agree to receive all treatment covered by the Grant at the Institute for Reproductive Health in Cincinnati, Ohio ("IRH").
- Applicant must begin IVF cycle within six (6 months) of the date the Grant was awarded. Grant cannot be used for past treatment or other services related to Applicant's (and Co-Applicant's) infertility.
- All Grant funds shall be paid directly to IRH. No Grant funds shall be paid directly to the Grant recipient. Should a refund be available from IRH due to services costing less than anticipated, services not being rendered, health insurance coverage, or for any other reason, Applicant understands that Parental Hope shall be reimbursed in **FULL** before the Applicant receives a portion of the refund.
- Grant award shall be contingent on a satisfactory criminal background check and credit check of Applicant and Co-Applicant.
- Applicant must agree to keep Parental Hope updated with the progress of any pregnancy and live birth resulting from treatment paid for by the Grant.
- Immediate family members (Parents, Children, Siblings, Nieces or Nephews, and First Cousins) of the Board of Directors or an Officer of Parental Hope shall not be eligible.
- All Applicants (and Co-Applicants) are expected to fully complete, execute and provide the documents and other information set forth on the Parental Hope Family Grant Application Checklist.

Process

- Application and other required documentation must be sent via regular mail and shall be postmarked by ***August 1, 2017***. Applications that are mailed late, are incomplete or are not received via regular mail

SHALL NOT be considered. Once received, a representative of Parental Hope will contact the Applicant via e-mail to confirm receipt.

- After all applications are received, the Board of Directors of Parental Hope will meet to review the Applications and determine which Applicant(s) will receive a Grant. The number of Grants awarded will vary from year to year and will be based on the financial strength of Parental Hope at that time. *Not all Applicants will receive a Grant and Grants may vary in amounts.*
- The chosen Applicant(s) shall be notified by the Board of Director's decision by December 1, 2017. Applicants who are not chosen shall be notified of the Board of Directors decision after all chosen Applicants have accepted the Grants.
- **Please do not contact Parental Hope during the review process.** A Member of the Board of Directors will notify you to confirm receipt of your Application and will contact you if more information is required.

Application Checklist

- Completed Grant Application. Applications must be typed. If additional space is needed, please attach a separate page.
- Video essay. Video essay shall be ***no longer than five minutes in length*** and shall be e-mailed to info@parentalhope.org. Video essay shall provide the following information:
    - Please tell us about yourself. Please include information on how you met, your hobbies, your family, and anything else that provides us with insight as who you are as people.
    - Please tell us about your infertility journey.
    - What does it mean to Applicant *and* Co-Applicant to be a parent?
    - Why should you be chosen as a Grant recipient?
- Proof of Income:
    - A full copy of the last two IRS tax returns for both Applicant and Co-Applicant.
    - A copy of the two most recent pay stubs from Applicant and Co-Applicant.
- Proof of previous costs and payments related to infertility treatments. **Note:** If Applicant is a current patient of IRH, a representative of Parental Hope will work with IRH to obtain the necessary costs and payments information. Please do not contact IRH to obtain this information.
- A photocopy of both sides of the Applicant's and Co-Applicant's health insurance cards.
- Proof of insurance coverage or lack of insurance coverage for infertility treatments. This can be in the form of a letter from health insurance company or copy of health insurance policy describing coverage regarding infertility medical procedures.
- $50 non-refundable application fee. Payment shall be in the form of personal check or money order and made payable to Parental Hope, Inc. Application fee is **NON-REFUNDABLE** and shall be considered a donation.
- Completed Medical Evaluation Form prepared by your physician. **Note:** If Applicant is a current patient of IRH, a representative of Parental Hope will work with IRH to complete your Medical Evaluation Form. Please do not contact IRH to complete the Medical Evaluation Form.
- Fully executed Media Consent and Release Form.
- Fully executed Medical Information Release Form (HIPAA Authorization).
- Fully executed Financial Account Release Form.
- Please mail completed Parental Hope Family Grant Application to the address below:

PARENTAL HOPE, INC.
P.O. BOX 42570
CINCINNATI, OHIO 45242

PARENTAL HOPE FAMILY GRANT APPLICATION

PERSONAL INFORMATION

APPLICANT[1]:

Last Name:_____ First Name:_____ Middle Initial:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Email Address: _____

Date of Birth:_____ Age:_____ Sex:_____

Social Security Number:_____

CO-APPLICANT[2]:

Last Name:_____ First Name:_____ Middle Initial:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Email Address: _____

Date of Birth:_____ Age:_____ Sex:_____

Social Security Number:_____

EMPLOYMENT INFORMATION

APPLICANT**:**

Occupation:_____Employer:_____

Date Employment Began:_____ Gross Salary:_____

Name of Previous Employer: _____ Job Title:_____

Dates of Employment: _____

CO-APPLICANT**:**

Occupation:_____Employer:_____

Date Employment Began:_____ Gross Salary:_____

[1] Applicant refers to the individual who will be receiving the infertility treatment.
[2] Co-Applicant refers to the Applicant's spouse, partner, or other significant other.

Name of Previous Employer: _____ Job Title:_____

Dates of Employment: _____

EDUCATION

APPLICANT:

Last School Attended: _____

Date of Graduation: _____

Highest Degree Earned: _____

CO-APPLICANT:

Last School Attended: _____

Date of Graduation: _____

Highest Degree Earned: _____

RELATIONSHIP BETWEEN APPLICANT AND CO-APPLICANT

Are you married to Co-Applicant?_____

If so, what is the date of your marriage? _____

If no, please explain the nature of your relationship: _____

_____

CHILDREN AND PRIOR PREGNANCIES

Does the Applicant or Co-Applicant have children? If so, please provide the following information:

Name	Date of Birth	Biological Parents

Has the Applicant ever been pregnant? If yes, how many times?_____

Has the Applicant had any miscarriages or losses? If so, please explain:_____

_____

Has the Co-Applicant ever been pregnant? If yes, how many times?_____

Has the Co-Applicant had any miscarriages or losses? If so, please explain:_____

_____

CRIMINAL AND MENTAL HISTORY

Has the Applicant or Co-Applicant ever been charged, detained, or arrested for a felony or misdemeanor?

If yes, please explain in detail:_____

_____

_____

Has the Applicant or Co-Applicant ever been treated for substance abuse? If yes, please explain in detail:_____

_____

_____

Has the Applicant or Co-Applicant ever been treated for a mental illness (bi-polar disorder, depression, etc.)? If yes, please explain in detail:_____

_____

_____

FINANCIAL SITUATION

INCOME:

Applicant's Net Monthly Income (after taxes, but before retirement contributions): _____

Co-Applicant's Net Monthly Income (after taxes, but before retirement contributions): _____

Does either Applicant or Co-Applicant receive income from any of the following:

a. Self-Employment Income
b. Dividends
c. Interest
d. Income from trusts or annuities
e. Pensions and retirement funds
f. Social Security
g. Disability, unemployment insurance or worker's compensation
h. Public Assistance (welfare, A.F.D.C. payments)
i. Income Producing Property
j. Other

If any of the above apply, please explain in detail:

_____

_____

_____

_____

ASSETS:

Does either Applicant or Co-Applicant own a savings, checking, certificate of deposit or money market account? If so, please provide the following for each account:

Bank Name	Type of Account	Current Balance

Does either Applicant or Co-Applicant own a retirement account (IRA, ROTH IRA, 401k, etc)? If so, please provide the following for each account:

Financial Institution	Type of Account	Current Balance

Does either Applicant or Co-Applicant own stocks, bonds or other investments? If so, please provide the following for each account:

Financial Institution	Type of Account	Summary of Assets	Current Balance

Does either Applicant or Co-Applicant own real estate? If so, please provide the following for each parcel of real estate:

Location	Owner Occupied	Ownership	Current FMV	Remaining Loan Amount

Does either Applicant or Co-Applicant own a motor vehicle? If so, please provide the following for each motor vehicle:

Year	Make	Model	Approximate Value

EXPENSES AND LIABILIITES

Please complete the following regarding your combined monthly expenses:

Expense	Average Cost/Month
Mortgage/Rent	$
Car payment	$
Utilities	$
Credit Cards	$
Alimony/Patrimony	$
Day care	$
Phones	$
Education loans	$
Entertainment	$
Eating Out	$

Groceries	$
Fertility treatment	$
Adoption savings	$
Other: _____	$
Other: _____	$
Other: _____	$
Total Monthly Expenses	$

Please complete the following regarding both of your creditors:

Owner of Liability (Applicant, Co-Applicant, Joint)	Creditor	Nature of Liability (Mortgage, Rent, Loans, etc.)	Total Amount Owed	Monthly Payment

Please complete the following regarding the credit cards each of you hold:

Owner of Credit Card	Credit Card Type	Current Balance

Does either Applicant or Co-Applicant pay alimony or child support? If so, please explain in detail: _____

_____

Has either Applicant or Co-Applicant ever filed for bankruptcy or been a party to a foreclosure action? If so, please explain in detail:_____

_____

_____

If a current patient of Institute for Reproductive Health, does Applicant or Co-Applicant have an outstanding balance owed for services performed? If so, what is the outstanding balance and do you have the ability to pay off this balance?_____

_____

MEDICAL HISTORY AND INSURANCE INFORMATION

GENERAL MEDICAL HISTORY:

Are you currently being treated or being seen for any medical conditions other than infertility? If yes, please

explain in detail including condition, dates of treatment, physician, etc._____

_____

_____

Are either of you currently taking any medications (other than for infertility)? If yes, please provide a list of all medications taken and reasons for taking such medication in the past two years._____

_____

_____

Does either Applicant or Co-Applicant smoke or use other tobacco products? If so, please explain in detail:_____

_____

Does either Applicant or Co-Applicant drink alcohol? If so, please explain in your alcohol use in detail:

_____

_____

INFERTILITY TREATMENT HISTORY:

Please set forth below the following information regarding the physicians and/or clinics where Applicant and Co-Applicant have received treatment regarding your infertility diagnosis: Clinic, Address, Dates of Treatment, Primary Physician, and Description of Treatment:_____

_____

_____

_____

_____

_____

_____

_____

_____

To the best of your ability and memory, please complete the following regarding Applicant and/or Co-Applicant's infertility treatments. If additional information or clarification is necessary, Parental Hope will work directly with IRH to obtain such information. Please do not contact IRH.

Treatment	Number of Cycles	Dates (Month/Year)	Outcome (baby, miscarriage, etc.)
Intrauterine inseminations (no medication):	_____	_____ _____ _____	_____ _____ _____
Clomid with timed intercourse with intrauterine inseminations with Metformin	_____ _____ _____	_____ _____ _____	_____ _____ _____
Letrozole/Femara with timed intercourse with intrauterine inseminations	_____ _____	_____ _____	_____ _____
Gonadotropins (Follistim, Gonal F, Menopur, Repronex, Bravelle) with intrauterine inseminations	_____	_____	_____
Complete IVF cycle(s): 1. # eggs _____ # fertilized _____ # transferred____ # frozen _____ 2. # eggs_____ # fertilized_____ # transferred ____ # frozen _____ 3. # eggs _____ # fertilized _____ # transferred ____ # frozen _____	_____	_____ _____ _____	_____ _____ _____
Frozen embryo transfers: 1. # embryos transferred_____ 2. # embryos transferred_____ 3. # embryos transferred_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

If not a current patient of IRH, please provide proof of costs, expenses, and payments of the above treatments.

Does the Applicant or Co-Applicant have any frozen embryos? _____

Do you need a donor egg for IVF? If yes, please provide details regarding need for donor egg and the egg donor, including age of donor:_____

_____

_____

Other than infertility treatments, are your pursuing parenthood through other avenues (adoption, etc.)? If yes, please explain in detail:_____

_____

_____

_____

HEALTH INSURANCE INFORMATION:

Does the Applicant have prenatal health coverage? _____

Does the Applicant or Co-Applicant have coverage or the ability to add coverage for a dependent?

_____

Does the Applicant or Co-Applicant have **ANY** insurance covering infertility procedures, medications, diagnosis, and/or treatment? If so, please explain in detail the benefits related to fertility treatment from the insurance policy and history of benefits received from fertility related treatments: _____

_____

_____

_____

_____

_____

_____

[Consent, Acknowledgment and Authorization on Next Page]

CONSENT, ACKNOWLEDGMENT AND AUTHORIZATION

By submitting the Parental Hope Family Grant Application ("Application"), Applicant and Co-Applicant ("Applicant") understand, authorize, certify and consent to the following:

- That Applicant is not a parent, child, sibling, niece or nephew, or first cousin of a Board Member or Officer of Parental Hope.

- That there are no willful falsifications, omissions or misrepresentations in the information provided by Applicant in the Application and that the above information stated in the Application is the full and complete truth to the best of Applicant's knowledge.

- That Parental Hope shall have authorization to verify the information contained in the Application via credit history, criminal history checks and other means necessary to verify the information.

- That if it is found that any information contained in the Application was falsified, omitted, or misrepresented, if the Application instructions were not followed, or if your family, fertility, or legal status changed following the submission of the Application and Applicant did not notify Parental Hope of such a change, the grant money, if offered, may be rescinded or forfeited at the discretion of Parental Hope.

- That Applicant shall keep Parental Hope updated with the progress of any pregnancy and live birth resulting from treatment paid for by the Grant. Information required in updates shall include confirmation of pregnancy, confirmation of miscarriage or other termination of pregnancy, and confirmation of live birth, including, but not limited to, name and sex of child. If there is a birth of a live child, after such birth, Applicant shall submit to Parental Hope a family picture and a short summary of Applicant's infertility journey and information relating to the child. Parental Hope shall use such information on its website and in other marketing materials as described in the Media Consent and Release Agreement.

- Applicant understands that they will not receive any money directly, but that the Grant awarded shall be paid directly to the Institute for Reproductive Health. Applicant understands that the treatment covered by the Grant shall occur within six months of date the Grant is awarded (the "Expiration Date"). Should a refund be available from IRH due to services costing less than anticipated, services not being rendered, health insurance coverage, or for any other reason, Applicant understands that Parental Hope shall be reimbursed in **FULL** before the Applicant receives a portion of the refund. Applicant confirms that all monies owed to IRH have been paid in full.

- Applicant understands that the Grant is not refundable, or redeemable for cash, and under no circumstances shall the Grant be transferred, sold or exchanged. In the event the Applicant cannot use the Grant prior to the Expiration Date, or has transferred, sold or exchanged the Grant, the Grant shall be forfeited and no compensation shall be given.

- Applicant understands that they are responsible for all Federal, state and local taxes, if applicable.

Signature of Applicant: _____ Date: _____

Signature of Co-Applicant: _____ Date: _____