SUBMISSIONS CHECK LIST (please include a copy of this with your application)

Before filling out the application, please make sure you meet the criteria on the first page of this application. Also, at any time please feel free to provide additional pages for any item(s) you need to explain in further detail. You must submit all of the following information with your completed application:

______ Copy of your personal statement

______ A copy of both sides of applicant’s insurance card and that of a partner (if applicable.)

______ Application fee of $50. Make check payable to Journey to Parenthood. (Please do NOT send money orders. Personal check or Cashier’s Check only.)

______ Proof of income with documentation for BOTH partners to include two most recent pay stubs from each party on application/copy of last IRS tax return

______ COMPLETED GRANT APPLICATION: (Includes personal, financial and medical portions) Your physician MUST complete the medical portion of the application or written statement for adoption requests. It is the applicant’s responsibility to obtain these pages from the physician and include them with the application.

ADOPTION APPLICANTS: Please have your physician either fill out the medical portion of this application or provide a written medical evaluation as to why you are unable to conceive and/or carry a child to birth.

** Please Note: Fertility clinics and physicians may require several days 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.
Journey to Parenthood - GRANT APPLICATION

Journey to Parenthood is a nonprofit organization that provides financial assistance and support to those battling infertility. We provide grants for those who cannot afford the high costs of fertility treatments, such as IVF, egg donation, as well as surrogacy and adoption. To apply for a Journey to Parenthood grant please fill out the following form and submit all required information, including a $50 application fee and we reserve the right to conduct a criminal background check for an additional fee. Thank you.

Application Deadline: ________________

(No Late Submissions will be accepted)

Send to: Journey to Parenthood
P.O. Box 553
Norwood, MA 02062

On a separate sheet of paper please provide a personal statement indicating why you (and your partner) have chosen to apply for a Journey to Parenthood grant. Include information about your efforts to conceive, your financial circumstances, and why you feel you would be a worthy candidate. Photos are welcome but will not be returned.

PERSONAL INFORMATION

Name of Applicant: ______________________________________________________________

Applicant’s Partner (if applicable): ________________________________________________

Home address: ____________________________________________________________ Street

________________________________________________________________________ City/State/Zip

Age: _____________________________ ____________________________

Applicant                                Partner
E-mail address: _____________________________________________________________ (Please print your e-mail address clearly so we can contact you.)

Phone: _____________________ (day)    __________________ (evening) ____________________(Cell)

Children in Household if any: _________________________ Age(s)

Date of marriage between applicant and partner___________________ If not married, describe your relationship and length of time together?

____________________________________________________________________________________

Procedure/Process seeking funds for (ie IVF, egg donor, Surrogacy, adoption):

___________________________________________________________________________________

Total estimated cost: ________________________________________________________________

Cost breakdowns:

Fertility Treatments:  physician _____________________________       lab fees __________________

Medications _______________________________________________________

Surrogacy:  Medications: ________________________________  Clinician Fees ______________

Attorney Fees :__________________________________________________________

Adoption:  Estimated fees ____________________ (Domestic or International) Which agency will you be going through?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

If selected, what amount could you contribute if any? ________________________________

3
EMPLOYMENT HISTORY (Please provide information for past 5 years)

Applicant’s Current Employer/Profession___________________________________________________

Employer’s Contact Information_________________________________________________________________

Job Title _________________________________ Work phone _________________________________
Salary ___________________________________ Dates of employment _________________________

Applicant’s Previous Employer ___________________________________________________________________

Employer’s Contact Information_________________________________________________________________

Job Title _________________________________________________________________________
Salary ___________________________________ Dates of employment _________________________

******************************************************************************

Partner’s Current Employer ________________________________________________

Employer’s Contact Information_________________________________________________________________

Job Title _________________________________ Work phone _________________________________
Salary ___________________________________ Dates of employment _________________________

Partner’s Previous Employer ____________________________________________________________________

Employer’s Contact Information_________________________________________________________________

Job Title _________________________________________________________________________
Salary ___________________________________ Dates of employment _________________________
EDUCATION

Applicant’s Education

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 may be asked to submit a complete background check at their expense. Cost is generally $25-$50. This would be in addition to the application fee.

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?__________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
GENERAL MEDICAL INFORMATION

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 treatments. (IUI, Clomid, IVF, pregnancy loss, etc.)

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

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

________________________________________________________________________________________

________________________________________________________________________________________

Has applicant or partner ever been treated for substance abuse? ____________If yes, please explain:

7
What medications do you currently take? (applicant)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

(partner)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
FINANCIAL INFORMATION

Gross Monthly Income from all Sources of you and your partner:

1. Base pay 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 (net of costs)

Please submit a copy of your last tax return (if filing separately please provide both you and your partner) so that we may verify the accuracy of the information provided.

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)
   __________(year)_______________(make)______________ (model) __________(blue book value)
   __________(year)_______________(make)______________ (model) __________(blue book value)
   __________(year)_______________(make)______________ (model) __________(blue book value)

7. Other (stocks, bonds, boats, RVs)
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

8. List all liabilities (mortgage, credit cards, loans, creditors, etc.) Please attach separate sheet if necessary

<table>
<thead>
<tr>
<th>Creditor</th>
<th>Liability</th>
<th>Date</th>
<th>Amount</th>
<th>Monthly Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Bank</td>
<td>(EXAMPLE) 1st Mortgage</td>
<td>(Example) 1-1-12</td>
<td>(EXAMPLE) 200,0000</td>
<td>(EXAMPLE) 1300</td>
</tr>
</tbody>
</table>
9. Are you or have you ever been in collection? ________________________________

10. Do you currently have any wage garnishments? ________________________________

11. Have you ever filed bankruptcy? (if so please explain)
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

All information submitted to Journey to Parenthood will be held in strictest confidence and viewed only by the Board of Directors as the selection committee. We thank you for your interest in Journey to Parenthood and wish each and every one of you the best in your journey to build a family.

No forms (photos, letters, etc) will be returned.

If you have any questions you may contact us at Journeytoparenthood@jtp.org

Please send application to:
Journey to Parenthood
PO Box 553
Norwood, MA 02062
MEDICAL EVALUATION (to be completed by the physician and returned to the applicant for mailing.)

PLEASE FEEL FREE TO ADD ANY STATEMENT IN SUPPORT OF THE PATIENT'S GRANT REQUEST.

Patient Name ____________________________________________________________________

Patient Age ___________________ DOB __________________

Partner Age ___________________

Length of infertility (months trying) ________________________________________________

Cause of infertility (choose all that apply)

Male    tubal/uterine    ovarian    unexplained    pregnancy loss    other

Other: Explain
___________________________________________________________
___________________________________________________________
___________________________________________________________

Prior treatments

Number of prior IUI’s _______________ Outcome ______________________________________

Number of prior IVF’s _______________ Outcome ______________________________________

Has the Applicant ever been pregnant? _______________ If yes, How many times _______________

How many live births? _______________ How many losses? ___________________________________

Does the Applicant have any frozen embryos? __________ If yes, how many and where are they kept?
___________________________________________________________________________________

What clinic or clinics have you been treated and/or are being treated?
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
Female Evaluation

Medical problems

__________________________________________________________________________________
__________________________________________________________________________________

Current medications

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Surgical history

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Ovarian reserve

Day 3 FSH/E2 ___________ AMH _______________ Antral Follicle count _____________

Tubal/Uterine

HSG result

Hydrosonogram

Hysteroscopy

Male work-up

Semen analysis (dates)

Volume _________________ (ml)  Sperm concentration ___________ (Million/ml)

Motility ________________

Normal morphology ________________ (indicate WHO or Kruger strict criteria)
What is your recommendation for treatment for this patient? _________________________
____________________________________________________________________________
____________________________________________________________________________
Type of medications and dose you plan to use: _________________________________
____________________________________________________________________________
____________________________________________________________________________
Total cost as quoted to patient: _________________________________________________

Physician cost ___________________________   Laboratory fees _______________________
Medication costs ____________________________

**Please see accompanying letter for further information on costs for applicants.

**THIS FORM HAS BEEN COMPLETED BY:**

Physician _________________________________

Clinic ____________________________________

Address __________________________________

Phone _________________________________

The above diagnosis and costs are accurate to the best of my knowledge.

_________________________________________  __________________________
Physician or Representative of Medical Practice   Date