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**

_____ 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

_____ 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 anything personal you wish to share about your journey thus far.

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? _____

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:

_____

_____

_____

_____

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**

Creditor	Liability	Date	Amount	Monthly Payment
(EXAMPLE) US Bank	(EXAMPLE) 1st Mortgage	(Example) 1-1-12	(EXAMPLE) 200,0000	(EXAMPLE) 1300

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