

KEEPING HOPE ALIVE

Application for Infertility Grant

Deadline for Submission: Friday, March 13th

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 fertility clinic? _____

Who is your doctor (fertility clinic)? _____

What is the address of your fertility clinic? _____

What is the phone number of your fertility clinic? _____

	<u>Female</u>	<u>Male</u>
State of Residency <i>(Must be DE, NJ or PA)</i>		
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 planning on attending the 2020 KHA Walk of Hope? ___ YES ___ NO

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

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?

<u>Procedure/Date</u>	<u>Out of Pocket Costs</u>	<u>Amount Covered by Insurance</u>

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?

<u>Procedure/Date</u>	<u>Out of Pocket Costs</u>	<u>Amount Covered by Insurance</u>

Any other pertinent medical information you would like to share:
