KEEPING HOPE ALIVE IVF

Application for Infertility Grant

Golf Outing: Sunday, September 27

Note: Golf Outing attendance is mandatory.

Only Fully Complete Application Packages Will Be Accepted

Applicant #1 Name _____ Applicant #2 Name _____

Home Phone # _____

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 clinic? _____

Who is your doctor? *Fertility Clinic* _____

What is the address of your clinic? _____

What is the phone number of your clinic? _____

	Applicant #1	Applicant #2
Name		
DOB		
Email Address		
Current Job Title		
Employer's Name		
Dates of Employment		
How did you hear about KHA Grant?		
If married, number of years?		
Mandatory attendance at golf outing 9/27. Can you attend?		
Do you have any biological children?		
Have you ever been arrested?		
Member of Any Organizations or Volunteer Groups?		

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:*

Do you plan on bringing guests to the 2026 KHA Golf Outing & Dinner? YES ____ NO ____

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

Personal Statement: Please submit a written (may be typed) statement indicating the potential importance of this grant for your family and why you are applying for this grant. Please include any extenuating life circumstances (examples: job loss, financial struggle, life changes, etc.) that should be considered by the committee as they review your application for the KHA Infertility Grant. *Please limit the length to the space below.*

We attest that we wrote this statement.

Signature #1 _____

Signature #2 _____ Date _____

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INCOME

Annual Household Income: Including combined adjusted gross income. (This should match Line 11 from IRS Form 1040 plus other annual revenue of Applicants):

$ _____

PLEASE UPLOAD AND ATTACH PAGES 1 & 2 ONLY OF YOUR 2025 SIGNED FEDERAL FORM 1040. IF 2025 FEDERAL RETURNS ARE ON EXTENSION, PLEASE UPLOAD 2024 FORM 1040 ALONG WITH 2025 W2 STATEMENTS.

Household Budget: Please complete the chart below to provide your family's monthly budget for a typical month.

Expenses	Average Monthly Cost
Mortage / Rent	**$**
Car Payments	**$**
Utilities	**$**
Credit Cards	**$**
Alimony / Patrimony	**$**
Education Loans	**$**
Other	**$**
Other	**$**
Other	**$**
Total Monthly Expenses	**$**

SAVINGS

What is your current total balance of savings and checking accounts?

Bank Name _____ Savings **$** _____ Checking **$** _____

Bank Name _____ Savings **$** _____ Checking **$** _____

Bank Name _____ Savings **$** _____ Checking **$** _____

Bank Name _____ Savings **$** _____ Checking **$** _____

What is the combined net worth of your retirement/IRA savings plans? **$** _____

Do you own any stocks or bonds or have any other investments? If yes, please indicate the total portfolio value:

$ _____

What will the grant funds be used for and how do you plan to allot the funds? Please list a proposed budget:

MEDICAL HISTORY FOR WOMEN 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 ____

**If yes, what was the cause?*

Surgical History

Current Medications

Do you smoke? YES* ____ NO ____ **If yes, how often / packs a day?* _____

Have you ever used illicit drugs? (Please specify) _____

If "YES" – when was last drug use? _____

What procedures and treatments has the patient already undergone and at what cost?

Procedure / Date	Out of Pocket Costs	Amount Covered by Insurance

Any other pertinent medical information you would like to share:

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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 ____

**If yes, what was the cause?*

Surgical History

Current Medications

Do you smoke? YES* ____ NO ____ **If yes, how often / packs a day?* _____

Have you ever used illicit drugs? (Please specify) _____

If "YES" – when was last drug use? _____

What procedures and treatments has the patient already undergone and at what cost?

Procedure / Date	Out of Pocket Costs	Amount Covered by Insurance

Any other pertinent medical information you would like to share:

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CONSENT

By submitting this application and signing below, the applicant(s) understand and consent to the following (initial each statement and sign below):

1. To have our names and photographs published and released by Keeping Hope Alive Inc. and any/all press releases should we be awarded a grant.
   _____ (intial) _____ (intial)

2. Submitting this application does not in any way guarantee that we will receive a KHA Infertility Grant.
   _____ (intial) _____ (intial)

3. We will not receive any money directly; the grant award will be provided directly to the service providers (fertility clinic).
   _____ (intial) _____ (intial)

4. The grant reviewers will be receiving personal medical and financial information and this information will not be shared with anyone outside the selection committee.
   _____ (intial) _____ (intial)

5. If we are awarded a KHA Infertility Grant, we understand that the monies received must be used within 12 months of receipt for the purpose requested and any unused monies will be returned to the KHA grant pool for future use.
   _____ (intial) _____ (intial)

6. Should a refund be available due to services costing less than anticipated, services not being rendered, the refund (up to the value of the grant amount) will be returned to the KHA Infertility Grant pool and that we (applicants) shall not be entitled to any direct compensation or refund.
   _____ (intial) _____ (intial)

7. If it is found that any information contained in this application was falsified, if instructions were not followed, or if your family, fertility, or legal status changed following the submission of this grant and KHA was not notified of such change, the grant money, if offered, may be rescinded or forfeited at the discretion of KHA Board.
   _____ (intial) _____ (intial)

8. KHA has the right to confirm that applicants are in good standing with their fertility clinic.
   _____ (intial) _____ (intial)

9. The information contained in this application is truthful. _____ (intial) _____ (intial)

Applicant #1 Signature	**Printed Name**	**Date**
Applicant #2 Signature	**Printed Name**	**Date**

PLEASE EMAIL FULLY COMPLETED APPLICATION WITH REQUIRED ATTACHMENTS TO
KEEPINGHOPEIVF@GMAIL.COM

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