EVERLASTING HOPE GRANT APPLICATION

SUBMISSION CHECKLIST:

1. **Submission:** Applications must be received by Everlasting Hope by July 31st, 2024. To avoid a last minute rush, please submit your application as early as possible. Do not send your submission with a "Signature Required," as this will delay receipt. Please send your application form along with application fee and all other requested documentation to:

   Everlasting Hope

   3000 N 14th Street, Suite 3A

   Bismarck, ND 58503

   Note: We do not accept applications submitted via fax or email. We strongly suggest that you retain a copy of your submission for your records and keep a record of your tracking number.

2. **Personal story**: Include a personal story describing: hobbies, profession, family history, why you would be a worthy candidate, ect. Be as creative as you would like. Personal stories can be submitted as 1-2 typed pages or an emailed video story. Have fun with this! Please be sure to include 1-2 photos in your typed story submission. Submit videos via email to tara@raisingeverlastinghope.org

3. **Insurance**: A copy of both sides of the applicant's insurance card and that of a partner.

4. **Fee**: Application fee of $25. The application fee is considered a donation which may be tax deductible. We only accept a cashier's check payable to Everlasting Hope, or use the online link provided on the grant page located on our website. All application fees help fund the Everlasting Hope Grant so we can continue to provide grants. Applications submitted without a fee will NOT be reviewed.

5. **Application documents**: The entire application form herein, including release form and medical packet. It is the applicant's responsibility to obtain these pages from the physician. Note that fertility clinics and physicians often require weeks to complete the medical form.

   a. Everlasting Hope Application including Physician Recommendation Form, Patient Authorization Form for Use, and Disclosure of Protected Health Information

   b. Media Release Form

   c. Applicant Liability Release Form

Do not submit original medical history documentation or any other documents not explicitly requested. We do NOT return submissions.

GRANT PROCESS:

- Grant is available to North Dakota residents only.

- All Applicants (and Co-Applicants) are expected to fully complete, execute, and provide the documents and other information set forth on the Everlasting Hope Grant Application Checklist. Applications WILL NOT be considered if not fully complete, so please take the time to review and complete the Application Checklist to ensure your Application is complete.

- All Applicants will have to complete the Grant Application within the time frame and any additional documentation listed within the Application Checklist. Applications must be received by Everlasting Hope by the deadline date of July 31st, 2024. No late submissions accepted.

- After all Applications are received, the Board of Directors of Everlasting 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. Everlasting Hope Grant amounts will be dependent on fundraising efforts and donations collected by Everlasting Hope. While we would love to offer grants to every applicant, please note not all applicants will receive grants. Even though we would like to, we cannot fund all those who apply.

- The chosen Applicant(s) shall be notified of the Board of Directors' decision in August 2024. 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 Everlasting 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.

SECTION #1: PERSONAL INFORMATION

Name of Applicant:

Applicant's Partner (if applicable):

Home address: (street address, city, state, zip code)

Applicant's age:	Partner's age:	Age(s) of children (if any):
Email address:		Military service (applicant or partner): explain
Re-enter email address (Print in capital letters):		
Daytime phone:		Evening phone:

I am a:
1st time applicant 2nd time applicant 3rd time applicant

SECTION #2: REQUESTED GRANT AMOUNT

I am applying for:
- ☐ Everlasting Hope Infertility Grant
- ☐ Simply You IUI Grant
- ☐ Both

Procedure needed:_____

Cost breakdown (do not attach clinic cost sheets):

Physician: $_____ Anesthesia: $_____

Lab fees: $_____ Facility: $_____ Other*: $_____

TOTAL (excluding medication): ……

$_____ Cost of medications:

…… $_____

Other medical fees you wish to include…… $_____

* *"Other" expenses can include egg donor or surrogacy fees, genetic testing, etc. You will be asked to detail these procedures and fees in the next section.*

** *Many applicants, regardless of grant status, are eligible for a discount on fertility meds. Visit www.fertilitysavings.com to find your percentage discount.*

SECTION #3: EXPLANATION OF "OTHER EXPENSES"

1. **Genetic testing:**

Are you doing genetic testing of any type, eg. CCS, PGS, PGD? Yes No

Which tests? _____ Cost? $_____

2. **Egg donation:**

Are you using an egg donor? Yes No Total cost: $_____

If yes: a) Is this donor contracted through an agency or is it friend/relative?_____

b) If through an agency, please name:_____

c) Are you doing a fresh or frozen transfer? _____

Please itemize the associated costs of egg donation (use separate sheet if necessary):

When do you anticipate being ready for embryo implantation? _____

3. **Surrogacy**

Are you using a surrogate to carry? Yes No Total cost: $_____

If yes: a)are you using a "known" surrogate or one hired through an agency? If agency, please name: _____

b) Are you doing a fresh or frozen transfer? _____

Please indicate the cost of each item if applicable:

a. Medical clearance for surrogate	$	b. Psych evaluation	$
c. Insurance for surrogate	$	d. Legal for surrogate and IP	$
e. Agency fee	$	f. Surrogate compensation	$
g. Clinic fees for transfer	$	h. Medication costs	$

Note: If using a surrogate, the medical evaluation form must be completed for the surrogate. If the surrogate is provided by an agency, the agency must provide proof of medical clearance.

SECTION #4: EMPLOYMENT HISTORY (for previous five years)		
APPLICANT:	Current employer, including contact information:	
	Job Title:	Work phone:
	Annual salary:	Dates of employment:
	Previous employer, including contact information:	
	Job Title:	Work phone:
	Annual salary:	Dates of employment:
PARTNER:	Partner's current employer, including contact information:	
	Job Title:	Work phone:
	Annual salary:	Dates of employment:
	Partner's previous employer, including contact information:	
	Job Title:	Work phone:
	Annual salary:	Dates of employment:

***Attach any additional employment history**.

SECTION #5: EDUCATION HISTORY		
APPLICANT:	Applicant's Education/Profession:	
	Last School Attended:	Date of Graduation:
	Highest Degree Earned:	
PARTNER:	Applicant's Education/Profession:	
	Last School Attended:	Date of Graduation:
	Highest Degree Earned:	

SECTION #6: CRIMINAL BACKGROUND
Have you (or your partner if applicable) been convicted of a felony or misdemeanor? If so, please provide details:

SECTION #7: FINANCIAL INFORMATION - INCOME

Total monthly household income before taxes: $_____

a. Monthly income: salary, wages	$	b. Self-Employment Income	$
c. Overtime, commissions, tips, bonuses, etc.	$	d. Dividends, interest	$
e. Income from trusts or annuities	$	f. Pensions, retirement funds	$
g. Social Security income	$	h. Disability, unemployment insurance, or worker's compensation	$
i. Public Assistance (welfare)	$	j. Income producing property	$

SECTION #8: FINANCIAL INFORMATION - 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:

7. List all liabilities (mortgage, credit cards, loans, creditors, etc.) Include amounts owed.

8. Are you or have you ever been in collections? Yes No

SECTION #9: HEALTH INSURANCE INFORMATION

APPLICANT:	Applicant's Insurance Provider:	
	Member Number:	Phone Number:
	Do you have Prenatal Coverage? Yes No	
	Do you have Coverage for Dependents? Yes No	
PARTNER:	Partner's Insurance Provider:	
	Member Number:	Phone Number:
	Do you have Prenatal Coverage? Yes No	
	Do you have Coverage for Dependents? Yes No	

Does either the applicant or partner have insurance that covers any infertility procedures (including medication, diagnosis, and/or treatment)? Yes No

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? Please include a specific dollar amount.

MEDICAL EVALUATION Complete to the best of your knowledge. Leave blank if not applicable.

Patient Information			
Patient Name:			
Height:	Weight:	BMI:	Age:
DOB:			
Partner Age:		Does either partner smoke? Yes No	
Length of infertility (months trying):			
Cause of infertility (check all that apply): ☐ Male tubal/uterine ☐ Ovarian ☐ Unexplained ☐ Pregnancy loss			
Prior Treatments			
Number of IUIs:	Outcome: ____ eggs, _____ fertilized, _____ transferred, _____ in storage		
Number of IVFs	Outcome: ____ eggs, _____ fertilized, _____ transferred, _____ in storage		
Date of last procedure:		Patient currently in treatment: Yes No	
If yes, please explain:			
Female Evaluation			
Medical problems:			
Surgical history:			
Ovarian reserve (day 3): FSH/E2: _____, AMH: _____, Antral Follicle count _____			
Tubal/Uterine:			
HSG result:		Date:	
Hydrosonogram:		Date:	
Hysteroscopy:		Date:	

Male Semen Analysis:		
Volume (ml):	Sperm concentration (million/ml):	Motility:
Normal morphology (WHO or Kruger strict criteria):		
Treatment Plan		
Recommended treatment for patient?		
Type of medications and dose you plan to use:		
Total cost excluding meds (excluding discounts; enter discount availability on pg 10): $_____ **Everlasting Hope DOES NOT pay for cryopreservation. Please do not include in cost.** Physician cost: $_____ Lab fees: $_____ Anesthesia: $_____		
Facility fee: $_____	Other: $_____	Includes ICSI? Yes No
Approximate medication cost: $_____ *Everlasting Hope strives to cover some of the medications WHEN POSSIBLE. We would ask that you prescribe the most efficient protocol while keeping price in mind as well.*		
Portion (if any) to be covered by insurance: $_____		

Have you or your partner ever been diagnosed with any of the following?
(circle all that apply)

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?
(circle all that apply)

Depression Bipolar disorder Personality disorder Other mental condition

If so, please explain in detail:

Applicant: what medications do you currently take?

Partner: what medications do you currently take?

ADDITIONAL INFERTILITY HISTORY

Note: This section is IN ADDITION to the personal story you are asked to submit.

Have you ever been pregnant? Yes No

Result?_____

When? _____

List any additional infertility history you feel we need to know.

Total expenses for past procedures: $_____	Still paying for these procedures? Yes No

What is your "clinic" history? Have you sought a second opinion, changed clinics, etc? Please detail.

When do you anticipate starting your treatment?

(Note that Everlasting Hope does not reimburse for procedures already begun)

PHYSICIAN RECOMMENDATION FORM

THE FOLLOWING MUST BE COMPLETED BY YOUR PHYSICIAN'S OFFICE:

What is your recommendation for treatment for this patient?

_____
_____
_____

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

_____
_____
_____

THIS FORM HAS BEEN COMPLETED BY:

Name _____Title _____
Clinic_____ Address
_____
_____

Phone _____ Email _____
Fax _____
The above statements are accurate to the best of my knowledge.

_____ _____

Physician Date

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize the clinic named below to disclose certain protected health information about me to Everlasting Hope.

This authorization permits the above mentioned clinic to disclose health information about me (and my partner, if applicable) for the purpose of applying for a grant from Everlasting Hope.

Clinic name:
Address:
Physician:

_____	_____	_____
Applicant: print name	Applicant: signature	Date
_____	_____	_____
Partner: print name	Partner: signature	Date

PLEASE TELL US HOW YOU HEARD ABOUT EVERLASTING HOPE:

(Check all that apply)

- ☐ Google Search: which keywords did you use to find us?_____
- ☐ Social Media: Facebook Instagram Twitter Other: _____
- ☐ Other media sources:_____
- ☐ TV segment: please specify _____
- ☐ Magazine article: please specify _____
- ☐ Other: please specify _____
- ☐ Family and friends
- ☐ Fertility Clinic:
  which?_____
- ☐ Other: _____

Please help us by subscribing to our newsletter and liking Everlasting Hope on Facebook and following us on Instagram and Twitter!