

SUBMISSIONS CHECKLIST

(Please include a copy of this checklist with your application)

Before submitting your application, ensure that you meet the criteria outlined on the first page. Feel free to provide additional pages if you need to explain any items in more detail. You must submit the following information along with your completed application:

- Copy of your **personal statement**
- Application fee** of \$50. (Make checks payable to Journey to Parenthood. *Do not send money orders; only personal or cashier's checks are accepted.*)
- Proof of income** for both partners, including two recent pay stubs from each party.
- Completed grant application**, including the personal, financial, and medical sections. (*Your physician must complete the medical portion or provide a written statement for adoption requests. It is the applicant's responsibility to collect these documents.*)

For adoption applicants:

Have your physician either complete the medical portion of this application or provide a written medical evaluation explaining 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. Be sure to allow your doctor enough time to complete it, as your application will not be considered complete without the medical forms.

JOURNEY TO PARENTHOOD GRANT APPLICATION

Journey to Parenthood is a nonprofit organization that provides financial assistance to individuals and couples struggling with infertility. We offer grants for those who cannot afford fertility treatments such as IVF, egg donation, surrogacy, and adoption. To apply, please complete the form and submit all required information, including the \$50 application fee. 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
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PERSONAL INFORMATION

- **Name of Applicant:** _____
- **Partner's Name (if applicable):** _____
- **Home Address:** _____
- **City/State/Zip:** _____
- **Age (Applicant):** _____ **Age (Partner):** _____
- **E-mail:** _____
- **Phone:** (Day) _____ (Evening) _____ (Cell) _____
- **Children in Household (if any):** _____ **Age(s):** _____
- **Date of Marriage (if applicable):** _____
- **If not married, describe your relationship and how long you've been together:**

Procedure/Process Seeking Funds For (e.g., IVF, egg donor, surrogacy, adoption):

- **Total estimated cost:** _____
- **Cost breakdown:**
 - Fertility Treatments: Physician: _____ Lab Fees: _____
 - Medications: _____
 - Surrogacy: Medications: _____ Clinician Fees: _____
 - Attorney Fees: _____
 - Adoption: Estimated Fees: _____ (Domestic or International)

- Which agency will you be using? _____
 - If selected, how much could you contribute? _____
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EMPLOYMENT HISTORY (Last 5 Years)

Applicant's Current Employer/Profession:

- Employer: _____
- Contact Info: _____
- Job Title: _____
- Work Phone: _____
- Salary: _____
- Dates of Employment: _____

Applicant's Previous Employer:

- Employer: _____
 - Contact Info: _____
 - Job Title: _____
 - Salary: _____
 - Dates of Employment: _____
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Partner's Current Employer:

- Employer: _____
- Contact Info: _____
- Job Title: _____
- Work Phone: _____
- Salary: _____
- Dates of Employment: _____

Partner's Previous Employer:

- Employer: _____
- Contact Info: _____
- Job Title: _____
- Salary: _____
- Dates of Employment: _____

EDUCATION

- **Applicant's Education:**
 - Last School Attended: _____
 - Date of Graduation: _____
 - Highest Degree Earned: _____
 - **Partner's Education:**
 - Last School Attended: _____
 - Date of Graduation: _____
 - Highest Degree Earned: _____
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CRIMINAL BACKGROUND

Grant finalists may be required to submit a complete background check at their expense (typically \$25-\$50), in addition to the application fee.

- **Have you (or your partner) been convicted of a felony or misdemeanor? If so, please provide details:**

HEALTH INSURANCE INFORMATION

- **Applicant's Insurance Provider:** _____
- **Member Number:** _____ **Phone Number:** _____
- **Prenatal Coverage?** _____ **Coverage for Dependents?** _____
- **Partner's Insurance Provider:** _____
- **Member Number:** _____ **Phone Number:** _____
- **Prenatal Coverage?** _____ **Coverage for Dependents?** _____
- **Does either applicant or partner have insurance that covers infertility procedures (including medication, diagnosis, or treatment)?**

- **What benefits have you received so far (if any)?**

GENERAL MEDICAL INFORMATION

- How long have you been trying to conceive? _____
- Have you ever been pregnant? If so, when? _____
- Provide any relevant information on infertility treatments (IUI, Clomid, IVF, pregnancy loss, etc.):

- Have you or your partner 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 been diagnosed with any of the following mental health conditions?
 - Depression: _____ Bipolar Disorder: _____ Personality Disorder: _____ Other: _____

 - If so, please explain in detail:

- Has either the applicant or partner ever been treated for substance abuse?
 - If yes, please explain:

- What medications are you currently taking?
 - Applicant:

 - Partner:

FINANCIAL INFORMATION

Gross Monthly Income from All Sources (for you and your partner):

1. Base pay from salary/wages: _____
 2. Self-employment income: _____
 3. Overtime, commissions, tips, bonuses, etc.: _____
 4. Dividends and interest: _____
 5. Income from trusts or annuities: _____
 6. Pensions and retirement funds: _____
 7. Social Security income: _____
 8. Disability, unemployment insurance, or workers' compensation: _____
 9. Public Assistance (welfare): _____
 10. Income from property (net of costs): _____
- **Please submit a copy of your last tax return.** (If filing separately, please provide tax returns for both you and your partner.)

JOINT AND INDIVIDUAL ASSETS

1. **List all properties owned, including locations and fair market values:**

2. **Pension fund values (IRA, Pension, Profit-sharing, etc.):**

3. **Life insurance present cash value:**

4. **Savings account balance(s):**

5. **Money market accounts and CDs:**

6. **Motor vehicles (year, make, model, and approximate Blue Book value):**

- Year: _____ Make: _____ Model: _____ Value: _____
- Year: _____ Make: _____ Model: _____ Value: _____
- Year: _____ Make: _____ Model: _____ Value: _____

7. **Other (stocks, bonds, boats, RVs, etc.):**

LIABILITIES

- **List all liabilities (mortgages, credit cards, loans, etc.).** *(Please attach a separate sheet if necessary.)*
 - Creditor: _____
 - Liability Type: _____
 - Date: _____
 - Amount: _____
 - Monthly Payment: _____

Example:

- Creditor: US Bank
- Liability Type: 1st Mortgage
- Date: 01/01/2020
- Amount: \$200,000
- Monthly Payment: \$1,300

FINANCIAL STATUS

9. **Are you or have you ever been in collection?** _____

- **If yes, please explain:**

10. **Do you currently have any wage garnishments?** _____

- **If yes, please explain:**

11. **Have you ever filed for bankruptcy?** _____

- **If yes, please explain:**

All information submitted to Journey to Parenthood will be held in the strictest confidence and reviewed only by the Board of Directors serving on the selection committee. Thank you for your interest in Journey to Parenthood, and we wish you the best in your journey to build a family.

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

If you have any questions, please contact us at:

- **Email:** Journeytoparenthood@jtp.org
- **Mailing Address:** 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 statements in support of the patient's grant request.

- Patient Name: _____
- Patient Age: _____ DOB: _____
- Partner Age: _____
- Length of infertility (months trying): _____
- Cause of infertility (check all that apply):
 - Male: ____ Tubal/Uterine: ____ Ovarian: ____ Unexplained: ____
 - Pregnancy Loss: ____ Other: ____
- Other (please explain):

PRIOR TREATMENTS

- Number of prior IUI treatments: _____ Outcome: _____
- Number of prior IVF treatments: _____ Outcome: _____
- Has the applicant ever been pregnant? _____
 - If yes, how many times? _____
 - How many live births? _____
 - How many pregnancy losses? _____
- Does the applicant have any frozen embryos? _____
 - If yes, how many and where are they stored?

- Which clinic(s) have you been treated at, or are currently being treated at?

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 EVALUATION

- **Semen analysis (dates):**
 - Volume: _____ (ml)
 - Sperm concentration: _____ (Million/ml)
 - Motility: _____
 - Normal morphology: _____ (indicate WHO or Kruger strict criteria)

TREATMENT RECOMMENDATION

- **What is your recommended treatment plan for this patient?**

- **Type of medications and dose you plan to use:**

- **Total cost as quoted to the patient:**
 - Physician cost: _____
 - Laboratory fees: _____
 - Medication costs: _____

Please see the 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 Medical Practice Representative Signature:**

- **Date:** _____