OUR MIRACLE CHILD GRANT APPLICATION

Grants are available to same-sex and heterosexual married couples who are permanent residents of the United States of America and fit the infertility criteria. This grant is meant for those who don't have sufficient insurance coverage or funds to afford infertility-related treatment/medication on their own.

SUBMISSION CHECK LIST:

- **Deadline:** Applications must be received by Our Miracle Child by the deadline date (**November 1, 2021**). No late submissions will be considered.

  To avoid any 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 and your application may not be received.

  Please mail your application form with all other requested documentation to:

  Our Miracle Child
  535 Penn Avenue
  Lancaster, PA 17602

  For any questions, please contact Our Miracle Child using our email address.
  Email: helplight@ourmiraclechild.com

  We do NOT accept applications submitted via fax or email. We strongly suggest that you keep a copy of your completed application for your records and keep a record of your tracking number.

- **Personal story**: Use this space to tell us about yourself - outlining hobbies, profession, family history, and anything else that may help us learn more about you! Do NOT document your fertility history here. Maximum 2 pages.

- **Photos**: Include at least one photo of both of the applicants.

- **Required essay**: Please review the list of prompts on the next page and choose ONE prompt you would like to respond to in an essay format. Please write which prompt you are responding to at the top of your essay. Our goal is to learn more about your fertility journey and why you would be a worthy candidate for the grant. Be as creative as you would like! Maximum 500 words.

- **Application form**: Please submit this entire application form, completed, including the release form and medical packet. Your physician MUST complete the medical portion of the application. It is the applicant's responsibility to obtain these pages from their physician. Note that fertility clinics and physicians may require some time to get the papers back to you.

- **Infertility funds**: The Our Miracle Child grant is not meant to cover full treatment and medication costs meaning you may have to supplement additional funds if you receive the grant. We strongly encourage you to apply to other charities in addition to the Our Miracle Child Foundation to procure sufficient funding for your fertility treatment.

- **Do not submit**: Medical history documentation or any other documents that are not explicitly requested. We do NOT return submissions.

Our Miracle Child receives many applications each cycle. We are limited by the amount of funds that are donated. Please know that we CANNOT fund all those who apply, even though we would like to.

REQUIRED ESSAY PROMPTS - CHOOSE ONE
Please choose ONE of the prompts below to respond to in an essay format. Write the prompt you chose at the top of your essay. 500 words maximum.
☐ Why do you believe you are the best candidate for this grant? ☐ How would you use this grant to continue your fertility journey? ☐ Why would this grant make the biggest impact for your fertility journey? ☐ Describe how infertility currently impacts your life and why this grant would benefit that journey. ☐ Describe your current fertility situation and how it affects you and your partner/family/friends, including how this grant could further benefit your situation. ☐ How would the award of the grant benefit you and other infertility couples in the future? ☐ How do you see yourself helping other members of the infertility community in the future? ☐ Want to create your own prompt? Please email helplight@ourmiraclechild.com with your suggestion so we can review it. Please allow ample time for us to review and approve your prompt. If we receive an essay with a prompt that has not been approved, we may ask you to resubmit your essay or your application may not be considered.

NOTE: Throughout this application, each partner will be referred to as "Applicant 1" or "Applicant 2". Please make sure that the information remains consistent for each applicant.

SECTION #1: PERSONAL INFORMATION		
Name of Applicant 1 (first and last):		
Preferred pronouns (Applicant 1):		
Name of Applicant 2 (first and last):		
Preferred pronouns (Applicant 2):		
Are you a married couple? ☐ Yes How many years have you been married? _____ ☐ No		
Home address (street address, city, state, zip code):		
Age (Applicant 1):	Age (Applicant 2):	Number of children (if any):
Age of children (if any):		
Living situation (check all that apply); indicate number of children per answer: ☐ Child(ren) lives/live with us: _____ ☐ Child(ren) doesn't/don't live with us: _____ ☐ Fostering child(ren) currently: _____ ☐ No children		
Note any other family details here:		
Email address:		Military service; explain:
Re-enter email address (Print in capital letters):		
Daytime phone:		Evening phone:
We are: ☐ 1st time applicants		☐ Returning applicants (indicate number of grant cycles you have applied for):

SECTION #2: TREATMENT FEES

Procedure needed:

Other details (Check all that apply):

☐ Using our eggs/sperm ☐ Using donor eggs/sperm ☐ Using gestational carrier

☐ Other (please specify any other details):

Cost breakdown (do not attach clinic cost sheets):

Physician: $_____	Anesthesia: $_____	Lab fees: $_____	Facility: $_____

Other expenses: $_____

Other expenses: Any fees associated with an egg donor, surrogacy or genetic testing, excluding medication.

TOTAL (excluding medication) .....$_____

Cost of medications.....$_____

Treatment and medication discounts

Indicate discount service(s) you are eligible for:

Indicate percentage discount (if applicable) .....%_____

If selected, what amount would you be able to contribute? $_____

Where would these funds come from (Check all that apply):

☐ Savings account ☐ Retirement savings account ☐ Saved money ☐ Other charities

☐ Other (please specify): _____

Note: The amount of money you would be able to contribute will NOT in any way disadvantage your application. It is Our Miracle Child's mission to help infertility couples afford infertility treatment regardless of whether they have sufficient personal funds. We want to understand the state of your infertility treatment savings and learn more about how we can help you best in affording treatment.

SECTION #3: EXPLANATION OF "OTHER EXPENSES"

1. **Genetic testing:**

Are you doing genetic testing of any type, eg. CCS, PGS, PGD?

☐ Yes Which tests?_____ Cost? $_____ ☐ No

- **Egg donation:**

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

  If yes:

- Is this donor contracted through an agency or is it a friend/relative? _____
- If through an agency, please name: _____
- 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? _____

- **Surrogacy**

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

  - If yes: are you using a "known" surrogate or one hired through an agency? If agency, please name: _____
  - Are you doing a fresh or frozen transfer? _____

Please indicate the cost of each item, if applicable (use separate sheet if necessary):

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		
APPLICANT 1:	Current employer, including contact information:	
	Job title:	Work phone:
	Annual salary:	Dates of employment:
	Previous employer (if applicable), including contact information:	
	Job title:	Work phone:
	Annual salary:	Dates of employment:
APPLICANT 2:	Current employer, including contact information:	
	Job title:	Work phone:
	Annual salary:	Dates of employment:
	Previous employer (if applicable), including contact information:	
	Job title:	Work phone:
	Annual salary:	Dates of employment:

SECTION #5: EDUCATION HISTORY		
APPLICANT 1:	Applicant's Education/Profession:	
	Last School Attended:	Date of Graduation:
	Highest Degree Earned:	
APPLICANT 2:	Applicant's Education/Profession:	
	Last School Attended:	Date of Graduation:
	Highest Degree Earned:	

SECTION #6: CRIMINAL BACKGROUND
Have either of you been convicted of a felony or misdemeanor? ☐Yes ☐ No
If the answer is yes, please explain, in detail:

SECTION #7: FINANCIAL INFORMATION - INCOME			
Total monthly household income <u>before</u> taxes: $_____			
a. Monthly income (salary, wages):	$	f. Pensions, retirement funds:	$
b. Self-Employment income:	$	g. Social Security income:	$
c. Overtime, commissions, tips, bonuses, etc.:	$	h. Disability, unemployment insurance or worker's compensation:	$
d. Dividends, interest:	$	i. Public Assistance (welfare):	$
e. Income from trusts or annuities:	$	j. Income producing property:	$

SECTION #8: FINANCIAL INFORMATION - ASSETS
Use a separate sheet, if necessary:
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):
7. List all liabilities (mortgage, credit cards, loans, creditors, etc.). Include amounts owed:
8. Are you or have you ever been in collection? ☐ Yes ☐ No

SECTION #9: HEALTH INSURANCE INFORMATION		
APPLICANT 1:	Applicant's Insurance Provider:	
	Member Number:	Phone Number:
	Do you have Prenatal Coverage? ☐ Yes ☐ No	
	Do you have Coverage for Dependents? ☐ Yes ☐ No	
APPLICANT 2:	Applicant'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 (use a separate sheet, if necessary):		
If your insurance covers any type of infertility treatment, what benefits have you received up to this point? Please include specific dollar amount (use a separate sheet, if necessary):		

SECTION #10: GENERAL MEDICAL INFORMATION

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

☐ Cancer ☐ Hepatitis ☐ HIV ☐ Diabetes ☐ Heart disease ☐ Other

If so, please explain in detail (use a separate sheet, if necessary):

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

☐ Depression ☐ Bipolar disorder ☐ Personality disorder ☐ Other mental condition

If so, please explain in detail (use a separate sheet, if necessary):

Applicant 1: What medications do you currently take?

Applicant 2: What medications do you currently take?

SECTION #11: INFERTILITY HISTORY

How long have you been attempting to conceive? _____

Have you ever been pregnant? ☐ Yes ☐ No When? _____	Result?

List any procedures you have had such as medications to stimulate IUI, IVF, etc., itemized by procedure (use a separate sheet, if necessary):

List dates, number of eggs produced and results (If needed, please submit on a separate sheet):	
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 explain in detail (use a separate sheet, if necessary).	
When do you anticipate starting your treatment? (Note that Our Miracle Child does not reimburse for procedures already begun. We ask that the grant money be used within 12 months of the grant recipient announcement date, unless other arrangements have been made among the Foundation, the applicants, and their physician.)	

SECTION #12: VOLUNTEERING
Are you willing to volunteer to support infertile families? ☐ Yes ☐ No
If the answer is yes, how will you help (please explain)?
Do you have any experience volunteering or fundraising? ☐ Yes ☐ No
If the answer is yes, please share more about your experience:

Grant Agreement Form

We will not receive any money directly; the grant award will be provided directly to the service providers (fertility clinic, pharmacy, or other related parties).

Signature (Applicant 1): Signature (Applicant 2):

Date:

If we are awarded the Our Miracle Child Grant, the money must be used within 12 months of the grant's commencement date (December 15, 2021) for the purpose that it was requested, and any unused funds will be returned to the Our Miracle Child Foundation, unless other arrangements are made amongst the Foundation, the applicants and their physician.

Signature (Applicant 1): Signature (Applicant 2):

Date:

Should a refund be available due to services costing less than anticipated, services not being rendered, a shared risk cycle is unsuccessful and funds are reimbursed by a clinic, that the refund (up to the value of the grant award) will be returned to the Our Miracle Child Foundation and that we (applicants) shall not be entitled to any direct compensation or refund until the Our Miracle Child Foundation has been refunded the value of the grant provided.

Signature (Applicant 1): Signature (Applicant 2):

Date:

The information contained in this application is truthful.

Signature (Applicant 1): Signature (Applicant 2):

Date:

Final Sign-Off

Include signatures of all applicants included on this application.

Signature (Applicant 1):

Signature (Applicant 2):

Date:

All information submitted to Our Miracle Child will be held in strictest confidence and viewed only by the selection committee. We thank you for your interest in Our Miracle Child and wish every one of you the best in your attempt to build a family. Please note that NO forms (photos, letters, etc) will be returned. We recommend that you a keep a copy of your application before mailing.

HOW DID YOU HEAR ABOUT OUR MIRACLE CHILD?

**Please check all that apply*

☐ Google search (which keywords did you use to find us?): _____

☐ Social media/Internet:

- ☐ Facebook
- ☐ Instagram
- ☐ Twitter
- ☐ Other social media: _____
- ☐ Website: _____

☐ Other media sources:

- ☐ TV segment: _____
- ☐ Magazine article: _____
- ☐ Newspaper article: _____
- ☐ Book: _____
- ☐ Other media source: _____

☐ Family and/or friends

☐ Fertility clinic:

- Name of clinic: _____
- Name of doctor: _____

☐ Other: _____

Please help the Our Miracle Child Foundation! Follow, like, and share our Facebook (@OurMiracleChildFoundation), Instagram (@ourmiraclechild_), and Twitter (@OurMiracleChil1) pages and posts! Any support is valued and appreciated greatly!

Thank you!

Personal Statement Release Form

The following form allows Our Miracle Child to use excerpts from your submitted essays (personal story and required essay). No last names will be used without permission. "The Applicants" refers to "Applicant 1" and "Applicant 2" of this grant application.

The Applicants hereby assigns and grants the Organization and its legal representatives the irrevocable and unrestricted right to use excerpts in whole or in part from The Applicants' personal statement and required essay and submitted photo(s) for editorial, trade, advertising, or any other purpose and in any manner and medium; to alter the same without restrictions and to copyright the same. The Applicants hereby release the Organization and its legal representatives and assign from all claims and liability relating to said excerpts and photos. Any person mentioned in The Applicants' personal statement and required essay shall be deemed to have consented to the use of their name, image, or likeness by The Applicants and/or Organization and The Applicants shall defend and indemnify the Organization from and against any claims that any of The Applicants' friends, family or other persons mention in the personal statement and required essay may assert against the Organization arising from, or related to, the use of any name, image, or likeness of The Applicants' friends, family or other persons mentioned in the personal statement and required essay by the Organization. Surnames will NOT be used so as to protect the identification of any of the above.

Print name (Applicant 1):

Signature (Applicant 1): Date:

Print name (Applicant 2):

Signature (Applicant 2): 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 Our Miracle Child Foundation, Inc.

This authorization permits the above mentioned clinic to disclose health information about me and my partner (Applicant 1 and Applicant 2) for the purpose of applying for a grant from Our Miracle Child Foundation.

Clinic name:
Address:
Physician:

Print name (Applicant 1): Signature (Applicant 1):

Date:

Print name (Applicant 2): Signature (Applicant 2):

Date:

I give my permission for Our Miracle Child to contact my physician and/or clinic's business manager:

Print name (Applicant 1): Signature (Applicant 1):

Date:

Print name (Applicant 2): Signature (Applicant 2):

Date:

MEDICAL EVALUATION (to be completed by the physician.)

Patient Information			
Patient Name:			
Height:	Weight:	BMI:	Age:
DOB:	Gravida:	Para:	Abortus:
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:
Current medications:
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 next page): $_____ *Note that Our Miracle Child 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: $_____ *We ask that you prescribe the most efficient protocol while keeping price in mind as well, as we hope to cover medication costs when possible.*		
Portion (if any) to be covered by insurance: $_____		

THIS FORM HAS BEEN COMPLETED BY:

Physician:	Clinic:	
Address:		
Phone:	Email:	Fax:

The above diagnosis and costs are accurate to the best of my knowledge.

Physician's Signature: Date:

Letter to Physician

Physician: _____ Clinic: _____

Email: _____ Patient's Name: _____

Dear Physician,

Your patient is applying for the *Our Miracle Child* grant and your help is needed.

The Our Miracle Child Foundation is a 501c(3) pending charity founded in 2021. Our mission is to grant financial assistance to those struggling with the high costs of infertility treatments such in vitro fertilization, egg and sperm donation, embryo donation, and gestational surrogacy, so that we can help as many people as possible hold their own miracle baby.

Please consider offering Our Miracle Child recipients financial help such as a 20% discount on services. **You are obligated to honor the discount ONLY IF the patient is selected as an Our Miracle Child grant recipient.**

☐ Our clinic would be willing to offer the grantee a $_____grant.

☐ Our clinic would match the Our Miracle Child Foundation grant up to a maximum of $_____.

☐ Our clinic would offer a grant of____% of the total cost (physician's fee and lab costs) excluding medications. Additional costs **not included** in above discount:

Anesthesia fee: _____ Facility fee: _____ ICSI: _____

Cryopreservation: _____ Other: _____

☐We are unable to offer this patient a discount.

If Our Miracle Child has questions about financial details for this patient, who should be contacted?

First name: _____ Last name: _____

Dept. at clinic: _____

Phone: _____ Extension: _____

Email: _____

We hope you will join Our Miracle Child in helping your patient. Access to sufficient financial funds is a prominent barrier to parenthood, and it is our mission to help infertility couples build a family, worry-free about treatment and medication costs. We thank you for helping your patient with their fertility journey. If you have additional questions, feel free to contact us (helplight@ourmiraclechild.com) or visit our website (https://ourmiraclechild.com) for more information.