SURROGACY MIRACLES FAMILY FOUNDATION GRANT APPLICATION

SUBMISSION CHECK LIST:

1. **Deadline:** Applications must be received by **Surrogacy Miracles Family Foundation** by the deadline date of 12/1/2022. No late submissions accepted.

   To avoid a last-minute rush, please submit your application as early as possible. Do not send your submission with missing "Signature Required" sections as this will forfeit your application

   Please send your application form along with application fee and all other requested documentation to:

   Surrogacy Miracles Family Foundation
   ATTENTION:GRANT APPLICATION DEPT
   1870 The Exchange Se
   Suite 200
   Atlanta GA 30339

   Note that 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 from the mailing.

2. **Personal story**: A personal story (maximum 2 pages). Do NOT document your fertility history here. We want to know who you are – hobbies, profession, family history, why you would be a worthy candidate. Be as creative as you would like. 1-2 photos included required.

3. **Insurance**: All applicants must provide a front and back copy of their insurance card. If applicants do not have insurance. Please provide a letter stating as such with signatures.

4. **Fee**: **Application fee of $100 is nonrefundable**. Make check payable to Surrogacy Miracles Family Foundation. We do NOT accept money orders. Bank Cashier's Check only. Applications submitted without a fee will NOT be reviewed. Our Fee price is set based on us accepting a limited number of applicants with an increased change for you to be selected as a grant recipient.

5. **Application form**: The entire application form herein, including 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 the physician. Note that fertility clinics and physicians often require weeks to complete the medical forms so make sure you have allotted enough time

to make the deadline.

6. **Do not submit**: Medical history documentation or any other documents not explicitly requested. We do NOT return submitted documentation.

Surrogacy Miracles Family Foundation receives hundreds of applications, but limit submission numbers for offered grants each year. We are limited by the amount of funds that are donated. We strive to be diverse in regards to ethnicity, sexual orientation, and geography. Please know that we CANNOT fund all those who apply, even though we would like to.

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 ☐ Returning multiple submissions		

SECTION #2: REQUESTED GRANT AMOUNT (Highlighted grant currently being offered)

☐ **Egg Donation Program $15,000 MAX**	**$100 Application Fee**
☐ **Egg Retrieval Program $10,000 MAX**	**$100 Application Fee**
☐ **Gestational Carrier Transfer $10,000 MAX**	**$100 Application Fee**
☐ **Surrogacy Agency Program $25,000 MAX**	**$100 Application Fee**
☐ **Funding the Future Family $30,000 MAX**	**$100 Application Fee**

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

Other*: $_____

Other expenses: the total of all costs listed on page 3 (any fees associated with egg donor, surrogacy or genetic testing, excluding medication.)

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

Cost of medications .....$_____

EMD Serono percentage discount (if applicable) ** .....%_____

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

SECTION #3: EXPLANATION OF "OTHER EXPENSES"

1. **Genetic testing:**

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

Which tests?_____ Cost? $_____

2. Egg donation: Select N/A if this does not apply to you N/A ☐

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

a) Is this donor contracted through an agency or is it a 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: $_____.

a) If yes: 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:

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

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

Please submit to a completed background check at your expense with the application.

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

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:	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 specific dollar amount.

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:

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:

Applicant: what medications do you currently take?

Partner: what medications do you currently take?

SECTION #11: INFERTILITY HISTORY

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

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.

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 detail.

When do you anticipate starting your treatment?

(Note that Surrogacy Miracles Family Foundation does not reimburse for procedures already begun)

Personal Statement Release Form

The following form allows Surrogacy Miracles Family Foundation to use excerpts from your personal statement. No last names will be used without permission.

The Applicant 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 Applicant's personal statement 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 Applicant hereby releases the Organization and its legal representatives and assigns from all claims and liability relating to said excerpts. Any person mentioned in Applicant's personal statement shall be deemed to have consented to the use of their name, image, or likeness by Applicant and/or Organization and Applicant shall defend and indemnify the Organization from and against any claims that any of Applicant's friends, family or other persons mentioned in the personal statement may assert against the Organization arising from, or related to, the use of any name, image, or likeness of Applicant's friend, family or other person mentioned in the personal statement by Organization. Surnames will NOT be used so as to protect the identification of any of the above.

Applicant: print name	Applicant: signature	Date

Partner: print name	Partner: signature	Date

I give my permission for Surrogacy Miracles Family Foundation to contact my physician and/or clinic's business manager:

Applicant	Partner	Date

All information submitted to Surrogacy Miracles Family Foundation will be held in strictest confidence and viewed only by the selection committee. We thank you for your interest in Surrogacy Miracles Family Foundation and wish each and every one of you the best in your attempt to build a family. No forms (photos, letters, etc) will be returned after submission.

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 Surrogacy Miracles Family Foundation.

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 Surrogacy Miracles Family Foundation.

Clinic name:
Address:
Physician:

Applicant: print name	Applicant: signature	Date
Partner (if applicable): print name	Partner (if applicable): signature	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:	
Saline Sonogram:		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 Surrogacy Miracles Family Foundation 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: $_____ *Surrogacy Miracles Family Foundation 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: $_____		

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 Date

Letter to Physician

Physician: _____ Clinic: _____

Email: _____ Patient's Name: _____

Dear Physician,

Your patient is applying for a Surrogacy Miracles Family Foundation grant and your help is needed.

Surrogacy Miracles Family Foundation is a 501c (3) charity founded in 2019. Our mission is to grant financial assistance to those struggling with the high costs of infertility treatments such in vitro fertilization, egg donation, embryo donation, and gestational surrogacy. The amount and service is based on availability.

Please join the many clinics offering Surrogacy Miracles Family Foundation recipients financial help such as a Pro Bono service or 20% discount on services. **You are obligated to honor the discount ONLY IF the patient is selected as a Surrogacy Miracles Family Foundation recipient.**

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

☐ Our clinic would match the Surrogacy Miracles Family 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 Surrogacy Miracles Family Foundation has questions about financial details for this patient, who should be contacted?

First name:_____Last name:_____Dept at clinic: _____

Phone:_____Extension:_____Email: _____

I hope you will join Surrogacy Miracles Family Foundation in helping the applicant. With the advance of technology, it is solely money which separates a couple from their dream of building a family. If you have additional questions, feel free to contact me or visit our website (www.surrogacymiraclesconsulting.org) for information and recent success stories.

Cordially,
Shadina Blunt,
Founder, Surrogacy Miracles
Family Foundation
404-484-4630

HOW DID YOU HEAR ABOUT SURROGACY MIRACLES FAMILY FOUNDATION?

**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 Surrogacy Miracle Family Foundation…Like us on Facebook and Follow us on Instagram and Twitter. Your help is greatly appreciated. Thank you!