Fertility Foundation of Texas
3801 N. Capital Of Texas Highway, E-240, PMB#131
Austin, Texas 78746
EMAIL FertilityFoundationOfTexas@gmail.com

GRANT APPLICATION FORM

APPLICANT #1

NAME: _____

EMAIL ADDRESS: _____

PHONE NUMBERS: (home) _____ (cell) _____

HOME ADDRESS: _____

HOW LONG HAVE YOU LIVED AT THIS ADDRESS?_____

DATE OF BIRTH: _____

HAVE YOU EVER BEEN CONVICTED OF A CRIME?_____

APPLICANT #2 (if applicable)

NAME: _____

EMAIL ADDRESS: _____

PHONE NUMBERS: (home) _____ (cell) _____

HOME ADDRESS:_____

HOW LONG HAVE YOU LIVED AT THIS ADDRESS? _____

DATE OF BIRTH: _____

HAVE YOU EVER BEEN CONVICTED OF A CRIME?_____

[Note: Fertility Foundation Of Texas (FFOTx) Grants are awarded to Central Texas residents only.]

PLEASE COMPLETE ALL OF THE FOLLOWING:

1. Total Household Income (from ALL Sources): $_____.

APPLICANT #1:

___ Attach 2 most recent INCOME TAX RETURNS

(Form 1040; with Schedules C & E, if applicable)

APPLICANT #1 cont.

___ Attach 2 most recent PAY STUBS

APPLICANT #2:

___ Attach 2 most recent INCOME TAX RETURNS

(Form 1040; with Schedules C & E, if applicable)

___ Attach 2 most recent PAY STUBS

2. Please list all other financial resources to help you pay for your infertility treatment:

___insurance? __ family? __friends? __savings? (please explain: _____

_____

_____.

3. The Physician treating our Infertility is: _____ . This doctor ____ IS _____ IS NOT a Board Certified Reproductive Endocrinologist**

4. Physician address/phone: _____
_____

2. How long have you been under the care of this physician? _____

3. Attach a TREATING PHYSICIAN FORM, signed by your physician. (Please note: Our Grants do not cover physician fees).

4. We _____ DO _____ DO NOT have health insurance coverage for infertility.

5. If you DO have health insurance coverage for infertility, have you exhausted your coverage for infertility treatments? ____ YES ____ NO

6. Our insurance provider is: _____

1. Attach a PHOTOCOPY of applicants' INSURANCE CARDS, FRONT AND BACK. By providing our signatures on this application, we hereby give Fertility Foundation of Texas permission to verify our insurance coverage.

**The Fertility Foundation Of Texas deems it necessary and relevant that the treating physician be a Board Certified Reproductive Endocrinologist for the purpose of awarding grant monies because this subspecialty of the American Board of OB/GYN is specifically trained to diagnose and treat INFERTILITY. Many potential infertility patients are treated early and successfully by their OB/GYNs. FFOTx grants are intended to reach only those patients with more complicated disease/treatment implications.

We, the undersigned, understand that signing and submitting this application does not, in any way, guarantee that we will receive a Fertility Foundation of Texas (FFOTX) grant. We also understand that we are submitting personal health and financial information to be reviewed by FFOTX in making a determination as to our qualification for a grant. This information will be treated as CONFIDENTIAL by FFOTX and will be used for review purposes only. We understand that if we qualify for a FFOTX grant we will not receive any money directly and this money will be paid by the Fertility Foundation Of Texas directly to the health provider, pharmacy, lab or other related parties on our behalf. None of the FFOTX grant money may be applied toward physician fees. We further understand that grant monies must be used within one year from the date of the award for the purposes for which it was requested, and that any unused monies will be held and reinvested by Fertility Foundation Of Texas for future grant awards to help others in need. We will not receive any unused portions of the FFOTX grant at any time. We have read, understand and agree to all the terms and conditions described in this grant application.

I/WE DECLARE THIS APPLICATION TO BE THE FULL TRUTH TO THE BEST OF MY/ OUR KNOWLEDGE.

SIGNATURES:

APPLICANT #1: _____

Printed Name: _____

Date: _____

APPLICANT #2: _____

Printed Name: _____

Date: _____