SPRING FERTILITY

Application for Spring Together Fertility Grant

PERSONAL INFORMATION:

Name _____ _____ **Gender** ☐ F ☐ M ☐ O
FIRST LAST

D.O.B. ___/___/___ **Email** _____
MM / DD / YY

Phone _____ **Address** _____
STREET ADDRESS CITY, STATE ZIP

Height _____' _____" **Weight** _____ **BMI** _____ **AMH** _____ ng/mL
FT. IN.

If applicable:

Partner Name _____ _____ **D.O.B.** ___/___/___
FIRST LAST MM / DD / YY

Have you completed fertility treatments elsewhere? ☐ Yes ☐ No

PERSONAL STORY:

INCOME VERIFICATION:

In order for your application to be considered complete, please also include at least one of the below accepted income verification documents.

- **1040**, **1040-A** or **1040-EZ**
- **IRS Tax Transcript**

p. (415) 964-5618 f. (415) 964-5619 e. springtogether@springfertility.com

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?** ___/___/___
MM / DD / YY

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?

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?

Please submit your completed application to springtogether@springfertility.com.

PERSONAL STATEMENT RELEASE FORM

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	SIGNATURE	DATE: DD / MM / YY
		/ /

Partner *If applicable:*

PRINT NAME	SIGNATURE	DATE: DD / MM / YY
		/ /

I give my permission for Spring Fertility to contact my physician and/or clinic's business manager:

APPLICANT	PARTNER (IF APPLICABLE)	DATE: DD / MM / YY
		/ /

All information submitted to Spring Fertility will be held in strictest confidence and viewed only by the selection committee. We thank you for your interest in the Spring Together Fertility Grant 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.

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 Spring Fertility.

Clinic Name _____

Clinic Address _____ _____
STREET ADDRESS SUITE # (IF APPLICABLE)

_____ _____ _____
CITY STATE ZIP CODE

Physician Name _____ _____
FIRST LAST

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 Spring Fertility.

Applicant:

_____ _____ / /
PRINT NAME SIGNATURE DATE: DD / MM / YY

Partner *If applicable:*

_____ _____ / /
PRINT NAME SIGNATURE DATE: DD / MM / YY

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