



## **EMBRACING HOPE GRANT APPLICATION**

FERTILE DREAMS  
GRANT ADVISORY BOARD  
COMMITTEE

**Timothy O'Leary, MD**  
Perinotologist,

Winnie Palmer Hospital for Women & Babies

**D. Ashley Hill, MD**

OB/GYN, Lockhaven OB/GYN, Orlando

**Amanda Ober**

Reporter, WESH Channel 2

**Melissa Brisman, Esq.**

Reproductive Lawyer

**Shawn Zimmerman, Ph.D**

Physician Support Services, Florida Hosp.

**N. Don Deibel, MD**

OB/GYN Specialists

### **ABOUT THE GRANT**

Fertile Dreams will select applicants who are uninsured for fertility treatment for a \$10,000 grant that can be used toward treatment at any fertility clinic in the United States.

### **THE EMBRACING HOPE GRANT PROCESS**

Applicants are reviewed and selected by a volunteer advisory board comprised of former patients and health care professionals. Applicants are asked to provide the following:

- O One page form supplied in information packet
- O Written description of their fertility history
- O Proof of income with documentation - a copy of the last two IRS tax returns and two most recent pay stubs from both partners
- O A signed copyright and media release giving Fertile Dreams full rights to tell your story if selected and to be photographed at anytime throughout the treatment process
- O Award winner must be available for the Award ceremony and Gala presentation in Orlando, FL. (See website for dates.)
- O Send completed application to the address below.

**Please contact Ingrid Burch with questions at 863.412.2774**



5931 Brick Court, Winter Park, FL 32792

321.397.3868 • FAX 407.678.2790

info@FertileDreams.org • www.FertilDreams.org

Fertile Dreams, is a 501 (c)(3) non-profit organization (TAX ID #202593865)



**REQUIREMENTS FOR GRANT**

Applicants must demonstrate financial need and be uninsured for fertility treatments. Female patient must be under the age of 40 when starting an IVF cycle. Application must be received by deadline date. See website for application deadline. All monies received through the Fertile Dreams

I/We understand that knowingly falsifying information will result in automatic rejection for participation in this award. I/We certify that all information is true and correct based on our knowledge. My/Our signature below acknowledges this fact.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FERTILE DREAMS MEDIA RELEASE FORM**

I/we grant permission to Fertile Dreams and its subsidiaries and sponsors to use my/our name and/or photographs or video media in or printed or electronic matter for use in publication and marketing materials. I/we further authorize the above entities to use my/ our name(s) and/or photographs or video media, or printed or electronic matter on its website or other electronic forms of media (“marketing materials”).

I /we hereby waive any right to inspect or approve the finished photographs or video media in printed or electronic matter that may be used now or in the future, whether that use is known to me/us or unknown, and I/we waive any right to royalties or other compensation arising from or related to the use of the photographs or video media in printed or electronic marketing materials.

I/we hereby agree to release, defend and hold harmless Fertile Dreams and its subsidiaries, including any firm publishing and/or distributing the finished product in whole or in part, whether on paper or via electronic media, from and against any claims, damages or liability arising from or related to the use of the photographs or video media in marketing materials.

\_\_\_\_\_ I/we have read this release before signing below and fully understand the contents, meaning and impact of this release. I/we understand that I/we am/are have had an opportunity to address any specific questions regarding this release by submitting those questions to Fertile Dreams in writing prior to signing, and/or by consulting a professional of my own choosing and I/we agree that my/our failure to do so will be interpreted as free and knowledgeable acceptance of the terms of this release.

Date: \_\_\_\_\_

Name: (Please print) \_\_\_\_\_

Partner’s Name: (Please print) \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_



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**EMBRACING HOPE GRANT FINANCIAL AFFIDAVIT**

**Gross Monthly Income from ALL Sources**

- Base Pay from salary and wages \$ \_\_\_\_\_
- Income from overtime, tips or bonuses \$ \_\_\_\_\_
- Income from trusts or annuities \$ \_\_\_\_\_
- Pensions and retirement funds \$ \_\_\_\_\_
- Disability, unemployment or worker's compensation \$ \_\_\_\_\_
- Public Assistance (welfare, etc.) \$ \_\_\_\_\_
- Rental monies from Income Producing Properties \$ \_\_\_\_\_
- All other sources \$ \_\_\_\_\_

**List ALL joint and individual applicant assets**

List ALL property owned including property location(s) and Fair Market Values

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

Savings account balances \$ \_\_\_\_\_

Money Market/CD Account balances \$ \_\_\_\_\_

Automobiles (please list year, make, model and approximate blue book values)

- a. \_\_\_\_\_
- b. \_\_\_\_\_

Other (Boats, RV's, stocks, bonds)

\_\_\_\_\_

**List ALL joint and individual applicant LIABILITIES**

Creditor Name	Nature of Liability	Date of Origin	Amount Owed	Monthly Payment



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**Embracing Fertile Dreams Hope** **Applicant Information**

Last:	First:	Middle:	___Mr. ___ Mrs. ___ Ms.    Date:
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Occupation	Employer Name & Phone	Date of Birth / /	Age	Sex ___ M ___ F
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Street Address	City	State	Zip	Social Security	Home Phone
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Email Address	Cell Phone	Alternate Contact Number:
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Do you or your spouse have insurance covering ANY fertility procedures? (meds, diagnosis or treatment)  
 \_\_\_Yes \_\_\_ No                      Please Explain: \_\_\_\_\_

Name & Phone Health Insurance Plans Applicant #1: \_\_\_\_\_ Spouse: \_\_\_\_\_

Do you have children? \_\_\_Yes \_\_\_ No                      If yes, how many? \_\_\_\_\_  
 Have you ever been pregnant? \_\_\_Yes\_\_\_ No    If yes, how many times \_\_\_\_\_ How many live births? \_\_\_\_\_ Losses? \_\_\_\_\_  
 Have you or your partner ever been pregnant or produced pregnancy? \_\_\_Yes \_\_\_ No    If yes, how many times? \_\_\_\_\_  
 Have you ever had an IVF Procedure? \_\_\_Yes\_\_\_ No    If yes, how many times? \_\_\_\_\_  
 With what physicians or clinic(s)?  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any frozen embryos? \_\_\_Yes \_\_\_NO    If yes, how many and where are they kept?  
 \_\_\_\_\_

Brief Fertility Summary: (diagnosis and history)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

On a separate sheet please tell why you are seeking this grant and a little more about your story. (Include any fertility history)

**Please be sure to read over your application before sending it.**  
**I/we the undersigned declare my/our application to be the full truth to the best of our knowledge.**

Signature Applicant #1 \_\_\_\_\_ Signature Applicant #2 \_\_\_\_\_