2020 GRANT APPLICATION FORM

Welcome to Congregation Beth Israel's Mishpacha Project! While we hope to assist all individuals/couples who apply, our funds are limited and will be distributed in consideration of numerous factors. Unfortunately, not all applicants will receive funding. Please know that the information provided will be held in the strictest of confidence. Upon completion please save this application as a PDF and email to: mishpachaproject@cbiaz.org.

PERSONAL INFORMATION		
Applicant 1 Name:		Date of Birth:
Phone:	Email:	
Current address:		
City:	State:	ZIP Code:
Own: Rent: (circle)	Number of people in household:	
Children:	Do you smoke? Yes / No (Circle)	
Years married? (if not married, years in relationship):		
Are you a member in good standing of Congregation Beth Israel? Yes / No (circle) If not, which Congregation Beth Israel member are you related to and what is the relationship?		
Have you ever been convicted or pled guilty to a felony or misdemeanor? Y / N		

Applicant 2 Name:		
Date of birth:	Phone:	
Email:		
Children:	Do you smoke? Yes / No (circle)	
Are you a member in good standing of Congregation Beth Israel? Yes / No (circle) If not, which Congregation Beth Israel member are you related to and what is the relationship?		
Have you ever been convicted or pled guilty to a felony or misdemeanor? Y / N (circle)		

PERSONAL STATEMENT
Our vision is to assist in build Jewish families my removing financial barriers to infertility treatment. Please attach a personal statement to help us learn more about you, including the following: personal background, summary of your infertility experience, financial implications of treatment and any concerns you may have as to the affordability of raising a child. Finally, we ask you to share a few ideas of your vision for your Jewish home and raising a Jewish child if treatment is successful (**800 words max**). While it is not required, you may also have a friend, rabbi or other Jewish professional leader submit a letter of reference to the *Mishpacha* Project.

FINANCIAL INFORMATION		
APPLICANT 1 EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		How long?
Phone:	E-mail:	
City:	State:	ZIP Code:
Position:	Hourly: Salary: (circle)	Annual income:
APPLICANT 2 EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		How long?
Phone:	E-mail:	
City:	State:	ZIP Code:
Position:	Hourly: Salary: (circle)	Annual income:

PREVIOUS INFERTILITY EXPENSES (PLEASE USE ANOTHER SHEET OF PAPER IF NEEDED)	
Previous infertility treatment and other extraordinary expenses incurred:	Date (s)

ADDITIONAL INFORMATION	
Have you ever filed bankruptcy? Y / N (circle)	Foreclosed on a home? Y / N (circle)
Do you have family or friends who have provided or are able to provide financial assistance?	
Additional information about your finances that we should know:	

ANTICIPATED TREATMENT COSTS
Please include all expenses (e.g. IUI, IVF, PGD, ICSI, anesthesia, Labs, Medications, etc.).

DESCRIPTION	Insurance coverage (% or $)	Your Cost
	Total:	

CONGREGATION BETH ISRAEL

Please describe any insurance coverage or relevant information such as previously covered fertility treatments, lifetime benefit maximums and usage, percentage coverage for any part of treatment, prescription coverage and/or any other financial assistance for which you have applied.

FUNDING REQUEST	
The Mishpacha Project typically funds up to $5,000. A personal contribution (of at least 20% of the total listed below) toward your treatment is required.	
	Amount
Personal contribution toward treatment	$
Assistance/grants from other sources (i.e. family members, friends)	$
Grant Request from Mishpacha Project	$
Total	$
For requests greater than $3,600 please include a copy of your Federal Income Tax Form 1040 (pages 1-2, which show your Adjusted Gross Income)	

MISHPACHA PROJECT GRANT APPLICATION
MEDICAL EVALUATION FORM
(Pages 4, 5, and 6 are to be completed by the physician.)

Patient's Name:

Height:	Weight:	BMI:

Patient Age:	Gravida:	Para:	Abortus:

Partner Age:	Does either smoke? ( ) Yes ( ) No

How long has patient been trying to conceive?

Cause of infertility (choose all that apply)
( ) Male ( ) Tubal/Uterine ( ) Ovarian ( ) Unexplained ( ) Pregnancy loss
( ) Other _____

Prior Treatments:
Number of prior IUIs _____ Outcome:_____
Number of prior IVFs _____ Outcome: _____
# of eggs: _____ # fertilized: _____ # transferred: _____ # in storage: _____

Female Evaluation:
Medical problems: _____
Current medications: _____
Surgical history: _____
Ovarian reserve: Day 3 FSH/E2: _____ AMH _____ Antral Follicle Count: _____
Tubal/Uterine:
HSG result: _____
Hydro sonogram: _____
Hysteroscopy: _____

Male work-up (if, applicable):
Medical problems: _____
Current medications: _____
Surgical history: _____
Semen analysis (dates): _____ .
Volume: _____(ml) Sperm concentration: _____(Million/ml)
Motility: _____
Normal morphology: _____ (indicate WHO or Kruger strict criteria)

Has your patient and her partner received genetic testing? ( ) Yes ( ) No
Are either carriers of a genetic disorder? ? ( ) Yes _____ ( ) No

What is your recommendation for treatment for this patient?
_____
_____

Is your patient scheduled for an assisted reproductive technology treatment?	Date to begin cycle:

MEDICAL EVALUATION FORM **TO BE COMPLETED BY PHYSICIAN**		
Please include pertinent labs, including patient's		
Total cost of treatment excluding meds: _____		
Physician cost:	Lab fees:	Anesthesia:
Other costs: _____ Includes ISCI? ( ) Yes ( ) No Cryopreservation? ( ) Yes ( ) No		
Approximate medication cost: _____ Portion to be covered by insurance (if any): _____		
Does your patient have Health Insurance? Yes/No		
Does the insurance cover fertility treatment? Yes/No		
Please include all pertinent labs and documentation. If you have any additional relevant medical information, please describe/explain here:		

THIS FORM AS BEEN COMPLETED BY:	
Physician:	
Clinic:	
Address:	
Phone:	Email:
The above diagnosis and costs are accurate to the best of my knowledge: _____ Physician's Signature _____ Date	

Dear Physician:

You have been given the enclosed medical form because your patient is applying for a fertility grant through Congregation Beth Israel's Mishpacha Project. Our mission is to grant financial assistance to those struggling with the high costs of infertility treatments such as intrauterine insemination, in vitro fertilization, egg retrieval, genetic testing and more. The Mishpacha Project's vision is to help toward shrinking the gap between the total costs and what the patient can contribute.

With this in mind, we are inquiring about the possibility of your providing a discount for services, whether this be a reduction in fees or a "pro bono" treatment cycle. If you can offer any discount, Congregation Beth Israel will provide you and/or your practice with all appropriate donation forms acknowledging your gift of services (i.e. Federal Tax ID number and 501 c 3 information).

Please note: You are obligated to honor the discount ONLY IF the patient is selected as a Mishpacha Project grant recipient.

__ Our clinic would be willing to offer the grantee a $_____ grant.
__ Our clinic would match The Mishpacha Project's grant up to a maximum of $_____.
__ Our clinic would offer a grant of _____ % off the total cost (physician's fee and lab costs) excluding medications.

Additional costs if not included in above discount:
Anesthesia fee _____ Facility fee _____ ICSI _____
Cryopreservation _____ Other _____

__ We are unable to offer this patient a grant.

If The Mishpacha Project has questions about financial details for this patient, who should be contacted?

First name: _____ Last name: _____
Department at clinic: _____
Phone: _____
Email: _____

As a physician who witnesses firsthand the frustration of couples facing infertility, I hope you will join The Mishpacha Project in helping the applicant. With the advance of technology, it is solely money which separates a couple from their dream of building their family.

Please feel free to contact us with any questions. Our website (www.cbiaz.org/mishpachaproject) has information on our process and future success stories.

Thank you,

[NAME]
The Mishpacha Project
mishpachaproject@cbiaz.org.