Maverick's Miracle Babies
Procreation Grant Application

MAVERICK'S MIRACLE BABIES MISSION STATEMENT:

Helping Families Afford Infertility Treatments

OUR MISSION:

Maverick's Miracle Babies Foundation helps families afford infertility treatments. Established in 2013, our nonprofit organization provides grants to qualifying families who are struggling to have a child. After being diagnosed with Poly-cystic Ovarian Syndrome, co-founders Tim and Kelsey Edwards experienced firsthand the financial and emotional struggles associated with infertility and infertility treatments. Fortunately, after numerous tests, a surgery, and 4 years of effort, Tim and Kelsey were able to beat the diagnosis and welcome a baby into their family. His name is Maverick and his arrival inspired the creation of Maverick's Miracle Babies Foundation. We help families who want a child but need a miracle.

ABOUT THE GRANT

The Maverick's Miracle Babies Procreation Grant is to be used for medical costs surrounding IUI and IVF procedures. Once a child is conceived, any remaining funds will return to the procreation grant fund to be used for another couple.

PROCREATION GRANT SELECTION PROCESS

Complete applications are reviewed and selected by the Board of Directors. The information contained in the grant application is considered confidential. Review of applications will occur at board meetings throughout the year. When the foundation receives your complete application you will get a notice in writing that states your application will be reviewed at the next available meeting. Incomplete applications will not be considered, therefore, please complete the application in its entirety, and be sure to include ALL the items on the checklist, as well as the checklist, with your application.

While we would love to offer grants to every applicant, not all applicants will receive grants.

What is covered (i.e. monitoring, lab work, medications, procedures, etc.) under the grant will be disclosed to each of the grant recipients at the time of award and funds from the grant will be given directly to the service providers (i.e. fertility clinic, labs, pharmacies, etc...).

APPLICATION DEADLINES

Q1: December 31st
Q2: March 31st
Q3: June 30th
Q4: September 30th

REQUIREMENTS FOR THE GRANTS

- Applicants must be legally married.
- Applicants must demonstrate financial need and have little to no insurance for fertility treatments.
- Applicants are legal permanent U.S. residents with citizenship.
- Applicants must reside in Texas and must be receiving treatments in Texas.
- Applicants must have an annual household income of more than $30,000 and less than $200,000
- Applicants must have a High School Diploma or GED
- Applicants with no children will be given priority.
- Applicants who have already spent funds on fertility treatment will be given priority.
- Applicants must meet the American Society for Reproductive Medicine definition of Infertility (i.e. blocked tubes, unexplained infertility, endometriosis, PCOS, male factor, female factor, etc.). A fertility specialist must officially diagnose infertility.
- Female applicant must be under the age of 40 when starting an IUI or IVF cycle.
- The grant is to be used exclusively for expenses surrounding IUI and IVF procedures.
- IUI and IVF treatments that require surrogacy or gamete donation are not considered for Procreation Grants.
- The grant may not be used to reimburse the applicant, medical providers, labs, or pharmacies for the services already received.
- All grant monies received through Maverick's Miracle Babies must be used within 365 days of the award date.
- All grant monies will be paid directly to medical service providers (i.e. fertility clinic, labs,
- pharmacies, etc...); no monies will be given directly to the applicant.
- All grant recipients will be subject to a criminal background check, credit check, and successfully passing a drug screen.

APPLICATION CHECKLIST

PLEASE COMPLETE CHECKLIST AND SEND IT BACK WITH APPLICATION

____ 1. Signed Copyright and Media Release Form, Consent Form, and Certification of Application Form (included in this application packet.)

____ 2. Applicant(s) Personal, Medical, and Health Insurance Information forms (included in this application packet.)

____ 3. Financial Information Sheet (included in this application packet.)

____ 4. Proof of income with documentation. Please include:

a. A copy of the last TWO IRS tax returns (Form 1040) including schedule C & E if applicable.
   Tax Returns required:
   - Married and filing jointly- Send in joint tax return
   - Married and filing separately- Send in both Applicants' tax returns.

b. A copy of the TWO most recent pay stubs from the Applicants

____ 5. Personal Statements: written description of infertility history/story from Applicant and Applicant's Spouse (Guidelines included in this packet)

____ 6. Letter from your current fertility specialist. (A letter is included in this application packet that should be printed off and given to your physician.)

____ 7. A photocopy of BOTH sides of the Applicants' insurance card(s).

____ 8. A Certified Copy of your Marriage License.

____ 9. Certified Copies of BOTH Applicants' birth certificates.

When the checklist is complete, mail the application and checklist to the address below:

Maverick's Miracle Babies
3000 S. IH-35
Suite 320
Austin, TX 78704

MEDIA RELEASE FORM

_____I/we grant permission to Maverick's Miracle Babies and its subsidiaries and sponsors to use my/our name and/or photographs or video media in 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 herby agree to release, defend and hold harmless Maverick's Miracle Babies 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 Maverick's Miracle Babies 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: _____

Applicant's Name: (Please print)

_____

Applicant's Spouse Name: (Please print)

_____

Address:

_____

_____

Applicant Signature: _____

Applicant's Spouse Signature: _____

APPLICANT PERSONAL INFORMATION

("Applicant" refers to the female receiving procedure(s))

APPLICANT INFORMATION:
LAST NAME: _____FIRST NAME: _____MIDDLE INITIAL: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
LENGTH OF TIME AT ADDRESS:_____HOME PHONE:_____
MOBILE PHONE: _____ WORK PHONE: _____
EMAIL ADDRESS: _____
RELIGIOUS PREFERENCE:_____
DATE OF BIRTH: _____ AGE: _____ SEX: _____
SOCIAL SECURITY NUMBER: _____
NAME OF FERTILITY CLINIC AND DOCTOR:_____
PHONE NUMBER OF CLINIC AND DOCTOR:_____
OCCUPATION: _____
EMPLOYER NAME AND PHONE: _____
DATE EMPLOYMENT BEGAN: _____ SALARY: _____
NAME OF PREVIOUS EMPLOYER: _____
DATES OF EMPLOYMENT: _____
JOB TITLE AT PREVIOUS EMPLOYER: _____

APPLICANT'S SPOUSE INFORMATION:
LAST NAME: _____FIRST NAME: _____MIDDLE INITIAL: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
LENGTH OF TIME AT ADDRESS:_____HOME PHONE: _____
MOBILE PHONE: _____ WORK PHONE: _____
EMAIL ADDRESS: _____
RELIGIOUS PREFERENCE:_____
DATE OF BIRTH: _____ AGE: _____ SEX: _____
SOCIAL SECURITY NUMBER: _____
OCCUPATION: _____
EMPLOYER NAME AND PHONE: _____
DATE EMPLOYMENT BEGAN: _____ SALARY: _____
NAME OF PREVIOUS EMPLOYER: _____
DATES OF EMPLOYMENT: _____
JOB TITLE AT PREVIOUS EMPLOYER: _____

CHILDREN LIVING IN YOUR HOUSEHOLD (part time and full time):

Name	Date of Birth	Biological Parents

DATE OF MARRIAGE BETWEEN APPLICANT AND APPLICANT'S SPOUSE: _____
PLEASE ATTACH A CERTIFIED COPY OF YOUR MARRIAGE LICENSE.

HAS THE APPLICANT OR THE APPLICANT'S SPOUSE EVER BEEN CHARGED, DETAINED OR ARRESTED FOR A FELONY OR MISDEMEANOR THAT WAS RESOLVED BY CONVICTION, PROBATION, DEFERRED ADJUDICATION, COURT ORDERED COMMUNITY SUPERVISION OR PRETRIAL DIVERSION OR THAT HAS NOT BEEN RESOLVED BY ANY METHOD? IF YES, PLEASE GIVE ALL DETAILS.

_____

_____

HAS THE APPLICANT OR THE APPLICANT'S SPOUSE EVER BEEN TREATED FOR SUBSTANCE ABUSE? YES NO
IF YES, PLEASE EXPLAIN:_____

_____

_____

HAS THE APPLICANT OR THE APPLICANT'S SPOUSE EVER BEEN TREATED FOR A MENTAL ILLNESS? YES NO
IF YES, PLEASE EXPLAIN PLEASE PROVIDE DOCUMENTATION NOTING STABILITY:_____

_____

_____

APPLICANT MEDICAL INFORMATION:

AGE:_____ HEIGHT:_____ WEIGHT:_____

LENGTH OF TIME CURRENTLY ATTEMPTING PREGNANCY:_____

GYNELOGICAL HISTORY:

HISTORY OF SURGERIES: _____
_____
_____
_____

HISTORY OF ENDEMETRIOSIS:_____
_____
_____

INFERTILITY TREATMENT:

HAS THE APPLICANT BEEN TREATED WITH CLOMID: YES NO
IF YES, NUMBER OF CYCLES: _____
IUI ATTEMPTED? YES NO

HAS THE APPLICANT BEEN TREATED WITH GONADOTROPINS (Gonal-F, Follistim, Braevelle, Menopur): YES NO
IF YES, NUMBER OF CYCLES: _____
IUI ATTEMPTED? YES NO

HAS THE APPLICANT EVER HAD AN IUI PROCEDURE? YES NO
IF YES, HOW MANY TIMES? _____

HAS THE APPLICANT EVER HAD AN IVF PROCEDURE? YES NO
IF YES, HOW MANY TIMES? _____
NUMBER OF EGGS RETREIVED? _____

DOES THE APPLICANT HAVE ANY FROZEN EMBRYOS? YES NO
IF YES, WHERE ARE THEY KEPT? _____

HAS THE APPLICANT EVER BEEN PREGNANT? YES NO
IF YES, HOW MANY TIMES? _____ HOW MANY LIVE BIRTHS? _____ LOSSES? _____

HAS THE APPLICANT'S SPOUSE EVER PRODUCED A PREGNANCY? YES NO
IF YES, HOW MANY TIMES? _____

DOES THE APPLICANT OR THE APPLICANT'S SPOUSE HAVE ANY CHILDREN AT ALL? YES NO

WITH WHAT PHYSICIAN (S) AND/OR CLINIC (S) HAVE YOU BEEN TREATED WITH INFERTILITY? _____
_____
_____
_____

DOES THE APPLICANT SMOKE? YES NO
IF YES, HOW MANY PACKS PER DAY? _____

DOES THE APPLICANT'S SPOUSE SMOKE? YES NO
IF YES, HOW MANY PACKS PER DAY? _____

WHAT MEDICATIONS DOES THE APPLICANT TAKE?_____
_____

SIGNIFICANT FAMILY MEDICAL HISTORY:_____
_____
_____

HEALTH INSURANCE INFORMATION

PLEASE ATTACH A PHOTOCOPY OF BOTH SIDES OF THE APPLICANT'S INSURANCE CARD AND THE APPLICANT'S SPOUSE'S CARD.

DOES THE APPLICANT HAVE PRENATAL COVERAGE? YES NO

DOES THE APPLICANT HAVE COVERAGE OR THE ABILITY TO ADD COVERAGE FOR A CHILD? YES NO

DOES THE APPLICANT OR THE APPLICANT'S SPOUSE HAVE **ANY** INSURANCE COVERING INFERTILITY PROCEDURES, MEDICATIONS, DIAGNOSIS, AND/OR TREATMENT? PLEASE BRIEFLY SUMMARIZE BELOW THE BENEFITS RELATED TO FERTILITY TREATMENT FROM THE INSURANCE POLICY AND HISTORY OF BENEFITS RECEIVED FROM FERTLITY RELATED TREATMENTS. (Applicant may attach their insurance plan's fertility benefits policy).

_____
_____
_____
_____
_____
_____
_____
_____
_____

FINANCIAL INFORMATION

Gross MONTHLY Income from ALL Sources
1. Base pay from salary, wages $ _____
2. Self Employment Income $_____
3. Income from overtime-commissions-tips-bonuses-part-time job $_____
4. Dividends - interest $ _____
5. Income from trusts or annuities $ _____
6. Pensions and retirement funds $ _____
7. Social Security $ _____
8. Disability, unemployment insurance or worker's compensation $_____
9. Public Assistance (welfare, A.F.D.C. payments) $ _____
10. Income Producing Property $ _____
11. All other sources $ _____
12. NET base income from salary, wages $_____

List ALL Joint and Individual Applicant Assets
(Attach additional pages if necessary)
1. List all Property owned including property location/s and Fair Market Values
a. _____
b. _____
c. _____
2. List pension fund values $ _____ (IRA, Pension, Profit Sharing, Other Retirement Plans, etc.)
3. Life Insurance: Present Cash Value $ _____
4. Savings account/s Balance: $_____
5. Money Market Accounts, and CDs values: $ _____
6. Motor Vehicles (year, make and model plus approximate Blue Book Values http://www.kbb.com)
a. Year:_____Make:_____Model_____Value_____
b. Year:_____Make:_____Model_____Value_____
c. Year:_____Make:_____Model_____Value_____
7. Other (stocks, bonds, collections, boats, RVs) $_____

List ALL joint and individual applicant LIABILITIES (attach separate sheet if necessary).

Creditor	Nature of Liability	Date of Origin	Amount Owed	Monthly Payment
	1st Mortgage			
	2nd Mortgage			
	Monthly Rent			
	Automobile			
	Automobile			
	Student Loans			

List ALL credit cards and their outstanding balances (attach separate sheet if necessary).

Credit Card(s)	Balance

List ALL fertility procedures and/or treatments already undergone and their cost.

Procedure/Date	Out of Pocket Cost	Amount Covered by Insurance

Please list any payments to and/or from Alimony and/or child support:_____
_____
_____

Are or were there any liabilities/credit cards in collection? _____
_____

Have you ever filed bankruptcy? _____

Do you have/had a home in the foreclosure process? _____

Applicant comments/notes about finances:_____
_____
_____
_____
_____

CONSENT FORM

We understand that by signing and submitting this application, we_____ and _____ (write in both names) understand that completing and submitting this application does not in any way guarantee that we will receive the Procreation Grant. We understand that the grant reviewers will be receiving personal medical and financial information and that this information will not be shared with anyone outside of the Board of Directors or Advisors to the Board. We understand that we will not receive any money directly and that the grant award will be provided directly to the health care providers, laboratories, pharmacies, or other related parties. We understand that if we are awarded a Procreation Grant that the money must be used within 365 days of the award and must be used for the purposes which it was requested, and that any unused funds will be returned to Maverick's Miracle Babies. Furthermore, we understand that should a refund be available due to services costing less than anticipated or services not being rendered, that the refund (up to the value of the grant award) will be returned to Maverick's Miracle Babies and that we (applicants) shall not be entitled to any direct compensation or refund until Maverick's Miracle Babies has been refunded the value of the grant provided. We have read, understood, and agree to all of the terms and conditions described in this grant application.

_____

Applicant Signature Printed Name Date

_____

Applicant's Spouse Signature Printed Name Date

CERTIFICATION OF APPLICATION

Please be sure to read over your application before sending it in.

I/We the undersigned declare my/our application to be the full truth to the best of my/our knowledge.

Signature of Applicant: _____
Signature of Applicant's Spouse: _____

I/we authorize verification of the information contained in this application via credit history, criminal history checks and other means. Please note that all grant awards are contingent upon background and credit checks and drug screen on both parties of the application.

Signature of Applicant: _____
Signature of Applicant's Spouse: _____

PHYSICIAN LETTER

(PLEASE PRINT THIS LETTER AND GIVE TO YOUR CURRENT FERTILITY SPECIALIST)

Dear Doctor,

Your patient has applied to Maverick's Miracle Babies for financial assistance for fertility treatment. Maverick's Miracle Babies is a 501(c)(3) nonprofit organization that administers grants to qualified patients seeking Intrauterine Insemination and/or In Vitro Fertilization.

In order to expedite the processing of your patient's application, we ask that you provide a letter summarizing your patient's care.

Please include:

- The reason for infertility
- Comments on semen analysis
- Comments on uterine cavity
- Comments on patency of tubes and ovarian reserve (ideally AMH level)
- AMH reserve
- Patients history of fertility tests, surgeries and treatments
- Patient's BMI
- Do you consider this patient a good candidate for IUI or IVF?

Thank you so much for your time and cooperation!

Best regards,

Maverick's Miracle Babies
3000 S. IH-35
Suite 320
Austin, TX 78704

PERSONAL STATEMENT GUIDELINES

Please submit a statement from EACH applicant (both SPOUSEs) describing your infertility history/story, the potential importance of this grant for your family, and why you are applying for this grant. Please include any extenuating life circumstances (examples: job loss, financial struggle, life changes, etc) that should be considered by the Board of Directors as they review your application for the Procreation Grant.