Gift of Hope 2013

Dear Applicant(s),

Thank you for your interest in the GIFT of HOPE sponsored by *Dr. John Storment, Fertility & Women's Health Center of Louisiana, Women's & Children's Hospital* and *Sheridan Healthcare*™. According to Resolve, the National Infertility Foundation, only a quarter of healthcare insurers offer coverage for infertility care. As a result, as many as 50 percent of American couples who fail to conceive do not seek treatment due to financial reasons.

The GIFT of HOPE was created to help one infertile couple overcome these financial barriers to building their family through the gift of an *in vitro* fertilization cycle. Couples faced with the high costs associated with infertility treatment, and the costs, both financially and emotionally, of other alternatives, such as adoption, can now apply for this true gift of hope.

The GIFT of HOPE has secured donated services to provide one couple the chance of pregnancy through *in vitro* fertilization. Donors include John M. Storment, M.D, reproductive endocrinologist with Fertility & Women's Health Center of Louisiana; the Assisted Reproductive Technologies Center at Women's & Children's Hospital in Lafayette, LA; and anesthesia services from Sheridan Healthcare™. An independent committee will review all submitted applications and select one couple to receive this gift of hope based upon their medical and financial needs and personal circumstances.

Applications may be downloaded from www.fertilityanswers.com or requested by calling (337) 989-8795. Applications must be accompanied by a letter from your referring physician summarizing your need for *in vitro* fertilization. **Applications must be received on or before Friday, April 26, 2013, 12:00 pm**. GIFT of HOPE will be awarded on May 6, 2013. Should you have any questions about this program, please email them to giftofhope@fertilityanswers.com.

Thank you!

Gift of Hope 2013

Donors:

- John M. Storment M.D., a board-certified reproductive endocrinologist with Fertility & Women's Health Center of Louisiana
- Assisted Reproductive Technologies Center at Women's & Children's Hospital
- Sheridan Healthcare™

Donated Services:

- Laboratory work done during the IVF treatment cycle
- Ultrasound exams done during the IVF treatment cycle
- Fertility medications prescribed for the IVF treatment cycle
- Retrieval of eggs
- Transfer of embryos
- Anesthesia for IVF retrieval and transfer
- Initial cryopreservation of unused embryos (includes one year of storage fees)

Services for Which Applicant May Be Required to Pay:

- Off-site storage of cryopreserved embryos
- Complications arising out of the IVF treatment
- Other or specialized laboratory testing expenses, as necessary or requested
- Travel expenses
- Other fees and costs not covered by donation
- Prescreening laboratory fees

GIFT of HOPE is Open to Any Applicant Who:

- Has a documented medical need for *in vitro* fertilization (i.e., blocked tubes, unexplained infertility, endometriosis, male factor infertility, etc.). A letter explaining this need is required, on letterhead, from a reproductive endocrinologist or gynecologic professional;
- Has a combined gross income of $80,000 a year or less before taxes (financial documentation is required)
- Is a resident of Louisiana;
- Can describe in their own words the compelling nature of their need for fertility treatment;
- Does not have insurance coverage for IVF;
- Has insurance coverage for prenatal care;
- Is in a married, stable relationship and consents to counseling prior to IVF treatment; and
- Agrees to appear in stories or other media about this program.

Application Instructions for GIFT of HOPE

- Please complete all sections of the application. Incomplete applications will not be processed.
- If you and/or your partner are self-employed, please include a letter describing your business, incorporation status and other details pertinent to your financial status.
- If you are not a current patient at Fertility & Women's Health Center of Louisiana you MUST have a letter of recommendation summarizing your need for *in vitro* fertilization from your reproductive endocrinologist or gynecologic professional. Please have your physician include any pertinent labs and medical records so that your need for *in vitro* fertilization can be more fully assessed. Without this information, the committee cannot fully evaluate your need for in vitro fertilization or chances of success with this treatment.
- Application and all required documents must be received on or before **April 26, 2013, 12:00 pm.** Please hand deliver or mail documents to:

Fertility & Women's Health Center of Louisiana
206 East Farrel Road
Lafayette, LA 70508
Attn: GIFT OF HOPE

- After we receive your completed application you will be notified by email or mail that it has been received. Please include a current email address on your application.
- If you have questions about the program or your eligibility, please email your questions to: giftofhope@fertilityanswers.com.
- Donation will be awarded on May 6, 2013 and applicant will be contacted by telephone. Winning applicant and partner must be available and present for a press conference at Women's & Children's Hospital (date TBA).
- Winning applicant will be required to sign Informed Consent and Acknowledgement of Risk forms from each donating entity before *in vitro* fertilization cycle commences.
- Winning applicant may be declined the award if they fail to meet prescreening needs for *in vitro* fertilization. In this case, another couple may be selected to receive GIFT of HOPE.

Gift of Hope

Application Checklist

To be considered for the GIFT of HOPE award, all applicants must provide the following information. Incomplete applications will not be considered.

- ✓ A fully completed and signed application form.
- ✓ A signed letter of referral (on letterhead) from a gynecological professional providing a diagnosis and medical need for IVF treatment, plus copies of any pertinent medical records or lab results.
- ✓ Proof of income/wages. This can be in the form of pay stubs from all employers for both partners (three most recent pay stubs) OR a copy of your 2012 Federal Income tax return (all returns if partners file separately). Please do not send original documents. Failure to provide sufficient documentation will disqualify your application.
- ✓ Copy of medical insurance cards (front and back) for both applicants (husband and wife).
- ✓ A personal letter to the committee explaining the compelling nature of the applicant's circumstances and struggles with infertility.
- ✓ A signed media release giving GIFT of HOPE full rights to tell the applicant's story.
- ✓ Application must be received on or before **Friday, April 26, 2013, 12:00 pm.**

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APPLICATION FORM

Please print and fill out **all** sections. Incomplete applications will not be processed.

APPLICANT INFORMATION

Applicant Name (First, Middle/Maiden, Last)	Applicant Marital Status ___Single ___Married ___Divorced ___Widowed ___Other	Any children? ___Y ___N Ages:
Applicant Occupation	Applicant Employer Name & Address Employer Phone #	Applicant Birthdate / / Age:
Home Street Address City State Zip		Applicant SSN
Applicant Email address	Cell #	Home #
Partner Name (First, Middle, Last)		Partner SSN
Partner Occupation	Partner Employer Name & Address Employer Phone #	Partner Birthdate / / Age:

Do either of you have Insurance covering ANY infertility procedures (meds, diagnosis or treatment)? ____Yes ____No

If yes, please explain:

INFERTILITY MEDICAL HISTORY

Current Gynecologist/Fertility Specialist Name & Address Phone Number

Have you ever been pregnant? ___ Yes ___ No If yes, how many times?_____ How many live births?_____ Losses?_____

Have you ever had an IVF procedure? ____Yes ____No If yes, how many? _____

With what physicians or clinics: _____

Do you have any frozen embryos? ____Yes ____No If yes, how many and where are they stored?_____

Do you smoke? ____Yes ____ No If yes, how much? _____ Height _____ Weight _____

Any other medical problems? _____

If applicant over 35 years of age, results of most recent FSH test: _____

Brief Fertility Summary (Diagnosis): _____

_____

APPLICANT SIGNATURES

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

X _____ _____

Applicant Signature Date

X _____ _____

Partner Signature Date

FOR OFFICE USE ONLY

Date received _____ Insurance:

Copyright and Media Release

Rights Granted to GIFT of HOPE

The undersigned, an applicant to participate in GIFT of HOPE, sponsored by Fertility & Women's Health Center of Louisiana, Women's & Children's Hospital and Sheridan Healthcare™, grants and conveys to GIFT of HOPE the exclusive rights to develop and tell the applicant's story related to the applicants efforts to build a family, including but not limited to information regarding the applicant and her partner, the applicant's immediate family members, the applicant's medical and financial struggles related to pregnancy, pregnancy loss, infertility, fertility treatment, etc. (known in this agreement and release collectively as your "Story"). Applicant grants GIFT of HOPE the exclusive right to share her Story in any and all media, now and hereafter developed, including but not limited to print media including books and magazines, and electronic media including all donors' websites and social media pages.

Applicant agrees to be truthful with respect to all information provided to GIFT of HOPE for inclusion in applicant's Story. Applicant understands that providing incomplete, inaccurate or false information will cause significant harm to GIFT of HOPE and agrees to indemnify and hold GIFT of HOPE and its respective donor organizations harmless against any claim, demand, or recovery brought against GIFT of HOPE as publisher of the applicant's Story with respect to any information applicant provides that is not complete, correct, accurate and truthful.

Upon selection for participation in GIFT of HOPE applicant agrees to provide GIFT of HOPE and/or its agents with photographs of applicant, applicant's partner and immediate family members and additional information to facilitate the telling of applicant's Story as requested by GIFT of HOPE. Applicant agrees to allow GIFT of HOPE and/or its representatives or agents to attend, photograph, videotape and otherwise record for purposes of telling applicant's Story, medical appointments and other events related to applicant's efforts to build a family.

Applicant agrees and understands that she/he shall receive only the donated medical services included in the program as consideration for granting these rights to GIFT of HOPE and its respective donor organizations and shall receive no other consideration or compensation for granting these rights. Applicant hereby waives claim to any royalties, fees or other compensation GIFT of HOPE may receive related to publishing or other telling of applicant's Story.

THE UNDERSIGNED APPLICANT AND PARTNER HAVE READ AND UNDERSTAND THE RIGHTS GRANTED TO GIFT OF HOPE AND ITS RESPECTIVE DONOR ORGANIZATIONS IN THIS COPYRIGHT AND MEDIA RELEASE AND VOLUNTARILY GRANT THE RIGHTS DETAILED IN THIS RELEASE TO GIFT OF HOPE IN CONSIDERATION FOR THE OPPORTUNITY TO APPLY TO PARTICIPATE IN THE GIFT OF HOPE PROGRAM.

_____ _____

Applicant signature Date

_____ _____

Applicant's partner signature Date