SPARKLES GARDEN OF LIFE GRANT APPLICATION

DATE: _____

How did you hear about Sparkles' Garden of Life Grant?

☐ Friend/Family Member ☐ Television ☐ Internet Search Engine ☐ Website: _____

☐ Other: _____

Thank you for your interest in the Sparkles' Garden of Life Grant. Please remember that all application materials must be submitted to **info@sparklesoflife.org** no later than **November 15, 2020.** All application materials, including the W2 form(s) and PayPal receipt, must be sent together in one email submission.

Application materials will be kept confidential and reviewed only by the Sparkles' Garden of Life Selection Committee. **The Garden of Life Grant has a cash value of $3,000 to be used for In Vitro Fertilization treatment. The grant pays the treatment exclusively and does not cover associated medical costs (i.e. medications, post-treatment medical procedures, etc.).** By submitting application materials to info@sparklesoflife.org, you are agreeing to find/provide the additional funding needed to cover the remaining cost of IVF treatment, if awarded the grant. Please note that submitting false information, or omitting critical information, will result in disqualification from the grant program.

CONTACT INFORMATION	
Full Name	
Address	
City, State, Zip	
Home Phone	
Mobile Phone	
Email Address	

PERSONAL INFORMATION

Date of Birth: (MM/DD/YYYY)	Gender: ☐ F ☐ M	Estimated Household Income:	Marital Status: ☐ S ☐ M ☐ D ☐ W If married, how long? _____ Yrs Spouse's name: _____ Spouse's Occupation: _____

How long have you lived in the Houston area? _____ Yrs

Current Job Title:	Address of Employment:	Name of Supervisor	Supervisor's Phone Number

Name and phone number of your fertility clinic and/or doctor:

Have you undergone In Vitro Fertilization Treatment before? ☐ Y ☐ N

Why are you applying for the Sparkles' Garden of Life Grant?

Does your insurance cover In Vitro Fertilization treatment? ☐ Y ☐ N

Do you currently have any children? ☐ Y ☐ N

GIVING BACK

Are you currently involved with any philanthropic or community organizations? ☐ Y ☐ N (If yes, please elaborate.)

Must be available to attend the **Annual Events** ☐ Y ☐ N (If no, please explain why not.)

Are you willing to volunteer at a Sparkles of Life fundraiser or advocacy event? ☐ Y ☐ N (If yes, explain how you would like to contribute.)

MEDICAL HISTORY FOR WOMEN

Height: _____ Weight: _____ Body Mass Index: _____

Length of time of currently attempting pregnancy: _____

Gynecological History

Age of first period: _____ Average length of menstrual cycle: _____

History of surgery: _____

_____

_____

History of endometriosis: _____

History of pelvic infections: _____

Obstetrical History

Check all that apply.

Pregnancy #	Year	Full Term	Preterm	Miscarriage	Terminations

Previous Infertility Testing

HSG results: _____ Laparoscopy: _____

Hysteroscopy: _____ Other gynecological surgery: _____

Ultrasound results: _____ Do you have fibroids? ☐ Y ☐ N

Do you have endometriosis? ☐ Y ☐ N If yes, which stage?

Previous Fertility Treatments

Procedure/Date	Out of Pocket Cost to You	Amount Covered by Insurance

Medical Problems: _____

_____

_____

Surgical History: _____

_____

_____

Do you smoke: ☐ Y ☐ N

What prescription/over the counter drugs to you take: _____

_____

_____

Have you used marijuana or other illegal drugs? ☐ Y ☐ N
(If yes, please detail which drugs and your frequency of use.): _____

_____

Significant Family Medical History: _____

_____

_____

Please detail any other important health and/or medical information you think the selection committee should know:

MEDICAL HISTORY FOR MEN

Height: _____ Weight: _____ Body Mass Index: _____

Length of time of trying to conceive: _____

Have you had any significant medical problems? _____

_____

_____

Please detail your surgical history: _____

_____

_____

Have you had any urological problems? ☐ Y ☐ N

Have you seen a urologist? ☐ Y ☐ N If yes, please write the urologist's name and phone number below:

_____

Have you ever fathered a pregnancy? ☐ Y ☐ N

If yes, when? _____ Was the child carried to full term? ☐ Y ☐ N

Have you been told that you have male infertility? ☐ Y ☐ N

If yes, what is/was the issue? _____

_____

_____

Sperm Analysis

Date	Count	Motility	Morphology

Have you ever been treated for cancer? ☐ Y ☐ N

If yes, what medications/treatments? _____

_____

_____

Medical Problems: _____

_____

_____

Surgical History: _____

_____

_____

Do you smoke: ☐ Y ☐ N

What prescription/over the counter drugs to you take: _____

_____

_____

Have you used marijuana or other illegal drugs? ☐ Y ☐ N
(If yes, please detail which drugs and your frequency of use.): _____

_____

Significant Family Medical History: _____

_____

_____

Please detail any other important health and/or medical information you think the selection committee should know:

DISCLAIMER

By signing below, I authorize Sparkles of Life, Inc. and the Sparkles' Garden of Life Selection Committee to obtain information - written, oral, or other - from my physician and any law enforcement agency, consumer reporting agency, or other persons with knowledge of such information, bearing on my character, general reputation, personal characteristics, mode of living, criminal background and driving record. Sparkles of Life reserves the right to conduct this investigation at any time.

I am aware that my name, address, telephone number, and e-mail address will be distributed to the Sparkles of Life board after the grant has been awarded. I understand that only my contact information will be available to board members, and all other information contained in the application materials will remain confidential, reviewed only by members of the selection committee.

The information I have given is correct and you may verify the information listed if necessary. I understand that selection is at the discretion of the Sparkles' Garden of Life Selection Committee and will not seek compensation of any sort in regard to the decision of the final awardees or the selection process/criterion.

(Electronic signatures are acceptable.)

Applicant Signature: _____ **Date:** _____

Spouse's Signature: _____ **Date:** _____