Tree of Life Grant
In Partnership with Fertility Foundation of Texas

3801 N. Capital of Texas Highway, Suite E-240, PMB #131
Austin, Texas 78746
TreeofLifeGrant.com
Email: FertilityFoundationofTexas@gmail.com
Please note "Tree of Life Grant" in the subject line

GRANT APPLICATION FORM

I. BORROWER INFORMATION

APPLICANT #1:

FULL NAME: _____

DATE OF BIRTH: _____

EMAIL ADDRESS: _____

PHONE: (home): _____ (cell): _____

PRESENT ADDRESS: (street, city, state, zip) ☐ Own ☐ Rent ____ no yrs

_____

MAILING ADDRESS: (if different from present address):

_____

If residing at present address for less than two years, complete the following

FORMER ADDRESS: (street, city, state, zip) ☐ Own ☐ Rent ____ no yrs

_____

HAVE YOU EVER BEEN CONVICTED OF A CRIME? ☐ Yes ☐ No (If Yes, please explain)

_____

HIGHEST DEGREE EARNED: (degree, school, graduation date)

_____

WERE YOU RAISED JEWISH? ☐ Yes ☐ No

DO YOU CONSIDER YOURSELF JEWISH NOW? ☐ Yes ☐ No

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II. BORROWER INFORMATION (CONT'D)

APPLICANT #2:

FULL NAME: _____

DATE OF BIRTH: _____

EMAIL ADDRESS: _____

PHONE: (home): _____ (cell): _____

PRESENT ADDRESS: (street, city, state, zip) ☐ Own ☐ Rent ____ no yrs

_____

MAILING ADDRESS: (if different from present address):

_____

If residing at present address for less than two years, complete the following

FORMER ADDRESS: (street, city, state, zip) ☐ Own ☐ Rent ____ no yrs

_____

HAVE YOU EVER BEEN CONVICTED OF A CRIME? ☐ Yes ☐ No (If Yes, please explain)

_____

HIGHEST DEGREE EARNED: (degree, school, graduation date)

_____

WERE YOU RAISED JEWISH? ☐ Yes ☐ No

DO YOU CONSIDER YOURSELF JEWISH NOW? ☐ Yes ☐ No

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III. EMPLOYMENT INFORMATION

APPLICANT #1:

EMPLOYER NAME: _____ ☐ Self Employed

EMPLOYER ADDRESS: (street, city, state, zip):

_____

POSITION/TITLE/TYPE OF BUSINESS: _____

YEARS ON THIS JOB: _____ YEARS EMPLOYED IN THIS LINE OF WORK: _____

CURRENT SALARY: _____ PREVIOUS YEAR'S SALARY: _____

APPLICANT #2:

EMPLOYER NAME: _____ ☐ Self Employed

EMPLOYER ADDRESS: (street, city, state, zip):

_____

POSITION/TITLE/TYPE OF BUSINESS: _____

YEARS ON THIS JOB _____ YEARS EMPLOYED IN THIS LINE OF WORK: _____

CURRENT SALARY: _____ PREVIOUS YEAR'S SALARY: _____

IV. INCOME AND EXPENSES

Gross Monthly Income	**Applicant I**	**Applicant II**	**Total**	**Combined Monthly Expense**	**Total**
Employer Income				**Rent/Mortgage**	
Overtime				**Auto**	
Bonuses				**Food**	
Commissions				**Outstanding Loans**	
Dividends/Interests					
Rental Income					
Other					
Total	**$**	**$**	**$**	**Total**	**$**

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V. ASSETS & LIABILITIES

If any accounts are not jointly held, please fill in a second page for Applicant #2.

ASSETS		LIABILITIES	
Name of Bank, S&L or Credit Union.	Cash or Market Value	Name of Company	Monthly Payment/Balance
			/
Name of Bank, S&L or Credit Union.	Cash or Market Value	Name of Company	Monthly Payment/Balance
			/
Name of Bank, S&L or Credit Union.	Cash or Market Value	Name of Company	Monthly Payment/Balance
			/
Stocks & Bonds	Cash or Market Value	Name of Company	Monthly Payment/Balance
			/
Life Insurance net cash value	$	Name of Company	Monthly Payment/Balance
			/
Subtotal Liquid Assets:	$	**Total Monthly Payments:**	$
Other Assets (Please list)	$	Other Liabilities (Please list)	$
	$		$

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	$		$
	$		$
	$		$
Total Assets	**$**	**Total Liabilities**	**$**
Net Worth (Assets minus Liabilities)	**$**		

Please list all other financial resources to help you pay for your infertility treatment (if awarded the grant, you will be responsible for unallowable expenses as well as any costs that exceed the grant):

☐ Insurance ☐ Family ☐ Friends ☐ Savings ☐ Other (please explain) _____

_____

_____

_____

VI. MEDICAL

1. The Physician treating your Infertility is: _____
2. This doctor ___ IS ___ IS NOT a Board Certified Reproductive Endocrinologist **
3. Physician Address: _____
4. Physician Phone: _____
5. How long have you been under the care of this physician? _____
6. Attach a TREATING PHYSICIAN FORM, signed by your physician. (Please note: Our grants do not cover physician fees).
7. I/We ___ DO ___ DO NOT have health insurance coverage for infertility.
8. If you DO have health insurance coverage for infertility, have you exhausted your coverage for infertility treatments? ___ YES ___ NO
9. My/Our insurance provider is: _____

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**The Fertility Foundation of Texas deems it necessary and relevant that the treating physician be a Board Certified Reproductive Endocrinologist for the purpose of awarding grant monies because this subspecialty of the American Board of OB/GYN is specifically trained to diagnose and treat INFERTILITY. Many potential infertility patients are treated early and successfully by their OB/GYNs. FFOTX grants are intended to reach only those patients with more complicated disease/treatment implications.

VII. CHECKLIST

Please NOTE: If any of the following items are not included, your application will be disqualified. If, for some reason, you do not have one or more of the items, please provide a letter of explanation for each missing item.

General

- ☐ Completed & Signed Application
- ☐ Treating Physician Form (NOTE: This physician should be the same one you continue your treatment plan with)
- ☐ Personal Story (Please dedicate a small portion of your statement to your vision for raising your child Jewish)
- ☐ PHOTOCOPY of applicants' INSURANCE CARDS, FRONT AND BACK. By providing our signatures on this application, we hereby give Fertility Foundation of Texas permission to verify our insurance coverage.
- ☐ Credit/Background Check Authorization

Applicant #1

- ☐ Attach 2 most recent INCOME TAX RETURNS (Form 1040; with Schedules C & E, if applicable)
- ☐ Attach 2 most recent PAY STUBS
- ☐ Attach 2 most current bank statements from active accounts listed on the application.

Applicant #2

- ☐ Attach 2 most recent INCOME TAX RETURNS (Form 1040; with Schedules C & E, if applicable)
- ☐ Attach 2 most recent PAY STUBS
- ☐ Attach 2 most current bank statements from active accounts listed on the application.

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We, the undersigned, understand that signing and submitting this application does not, in any way, guarantee that we will receive a Tree of Life grant (TOL) or Fertility Foundation of Texas (FFOTX) grant. We also understand that we are submitting personal health and financial information to be reviewed by FFOTX in making a determination as to our qualification for a grant. This information will be treated as CONFIDENTIAL by FFOTX and will be used for review purposes only. We understand that if we qualify for a TOL grant, we will not receive any money directly and this money will be paid by the Tree of Life grant in partnership Fertility Foundation of Texas directly to the health provider, pharmacy, lab or other related parties on our behalf. None of the TOL grant money may be applied toward physician fees. We further understand that grant monies must be used within one year from the date of the award for the purposes for which it was requested, and that any unused monies will be held and reinvested by Tree of Life/Fertility Foundation of Texas for future grant awards to help others in need. We will not receive any unused portions of the TOL grant at any time. We have read, understand and agree to all the terms and conditions described in this grant application.

I/WE DECLARE THIS APPLICATION TO BE THE FULL TRUTH TO THE BEST OF MY/ OUR KNOWLEDGE.

SIGNATURES:

APPLICANT #1	APPLICANT #2
PRINTED NAME	PRINTED NAME
DATE	DATE