Grant Application

Grant Application

Thank you for your interest in The Samantha and Kyle Busch Bundle of Joy Fund (The Bundle of Joy Fund) and our grant award program. We sincerely appreciate you sharing your journey with us, and the time and energy you invested in the application process.

The Bundle of Joy Fund exists to eliminate the financial barriers that prevent access to Assisted Reproductive Technology (ART) by awarding grants to people who will require in vitro fertilization (IVF) to build their family.

Grant awards are distributed up to three times annually. The number of grant awards and the total amount of funding awarded each cycle may fluctuate based on the following variables: 1) the unique needs and circumstances of the applicant, and 2) the success of our fundraising efforts. Our mission is to award as many grants to as many people as possible.

Qualifications

Applicants must be current patients of and received an infertility diagnosis from one of our partnering fertility clinics. Additionally, applicants must be legal permanent U.S. Citizens, age 18 or older to qualify. All applications are reviewed and considered regardless of race, religion, ethnicity or national origin, age, or sexual orientation.

Process

Applications should be obtained from and submitted to the partnering fertility clinic where they will be reviewed for medical accuracy. Once medical accuracy has been verified, The Bundle of Joy Fund review committee is responsible for final review and selection.

The Bundle of Joy Fund review committee may include members of the partnering fertility clinic staff, members of The Bundle of Joy Fund Board of Directors, and a minimum of two (2) members of The Bundle of Joy Fund staff, including but not limited to Founder and Executive Director, Samantha Busch.

Application review will take place within 6-8 weeks after the grant application deadline, with grant reveals scheduled within 60 days of the grant application deadline.

Instructions

Applications should be obtained from and submitted via one of our partnering fertility clinics.

All information provided within this application is considered confidential and will not be shared with any agency or person(s) outside of the partnering fertility clinic or The Bundle of Joy Fund and its Board of Directors / agents.

Please review the entire application before beginning to allow yourself ample time to complete all steps of the process, particularly the financial background and treatment estimate portions. If you have any questions about our partnering fertility clinics or the application process, please contact our Managing Director, Jessica Tuner at jessica.turner@bundleofjoyfund.org.

Gudelines

1. Your application must be filled out completely and truthfully to be considered. Applications that are missing information or attachments will not be reviewed and consideration will be withdrawn. Please find the checklist on a subsequent page. *Applicants should see a nurse, doctor, or the financial department at the partnering fertility clinic for help to complete any portion of this application.*

2. Support is considered only for people who are legal permanent U.S. Citizens with a documented infertility diagnosis from a partnering fertility clinic. Applicants must be a current patient of a partnering fertility clinic and have been seen by a physician at the partnering fertility clinic within the last 6 months.

3. Applications should be submitted by the deadline. Late applications will not be considered. There will be no exceptions to this rule.

4. Applicants should immediately report any changes in diagnosis, family status or contact information that occur after an application is submitted. Failure to report changes to the partnering fertility clinic may result in forfeiture of a grant award.

5. The amount of each grant award will be determined based on the unique needs and circumstances of the applicant and the treatment estimate provided by the partnering fertility clinic, less applicable discounts. The maximum grant amount is $20,000 per household.

6. Grant awards are distributed directly to the partnering fertility clinic, not the grant award recipient(s).

7. All applicants are required to apply to the Compassionate Care Program through EMD Serono, which provides eligible patients with cost savings on medications based on income. Responses are typically received within 2-3 days of applying, and eligible patients may save 25%-75% on the self-pay price of EMD Serono fertility medications. Applicants who do not receive a grant award from The Bundle of Joy Fund may still benefit from Compassionate Care Program savings.

8. Grant awards may only be applied to treatment *not yet received*. Funding cannot be applied to balances owed or treatment that is already in progress.

9. Grant awards do not cover IUIs or other infertility-related treatments and cannot be applied to multi-cycle Attain IVF programs. Grant awards may only be applied to the following treatments / services related to infertility treatments from the partnering fertility clinic:

   a. Single cycle IVF

   b. Donor cycle IVF

   c. Embryo adoption

   d. Frozen embryo transfer

   e. Genetic testing

   f. Medication

   g. Anesthesiology

10. Grant awards must be used within 12 months of the date of disbursement unless otherwise approved by The Bundle of Joy Fund.

11. If a grant award recipient does not exhaust the full amount of the funds provided, ancillary funds will be returned to The Bundle of Joy Fund.

12. Completed applications should be submitted via the partnering fertility clinic to be reviewed for medical accuracy.

13. Applicants that apply and do not receive a grant award may submit a new application for the next grant award cycle. *Applications are not saved and must be resubmitted to be considered for a subsequent grant award cycle.*

14. One grant award per household. Existing grant award recipients are ineligible to reapply for additional funding, and duplicate applications will not be considered.

15. Grant award recipients may be contacted at regular intervals throughout treatment and should contact The Bundle of Joy Fund to report a pregnancy to allow the organization to report results with accuracy.

Deadlines

Cycle I: Friday, March 1

Cycle II: Monday, July 1

Cycle III: Friday, November 1

Checklist

I am a current patient at a partnering fertility clinic with a diagnosis of infertility, which will require IVF treatment.

I have been seen by a physician at the partnering fertility clinic within the last six months.

I am applying for a grant award to apply to treatment not yet received.

I am legal permanent U.S. Citizen.

I have received and attached an official treatment estimate from the partnering fertility clinic required to complete the Treatment Estimate portion of the application.

I have reviewed my infertility insurance benefits, if applicable, required to complete the Health Insurance portion of the application.

I have reviewed pay stubs, W-2s and other financial documents required to complete the Financial Information portion of the application.

I have applied for the Compassionate Care Program (www.fertilitysavings.com) and attached the response.

I have completed the entire grant award application.

I have attached personal impact statements required to complete the Personal Impact Statement portion of the application.

I have attached photos of my family and me and recognize that photos will not be returned.

Cover Sheet

Applicant 1

Name:

Age:

Date of Birth:

Applicant 2

Name:

Age:

Date of Birth:

How did you hear about The Bundle of Joy Fund?

Family / Friend

Referral | Referral Name:

Social Media

Television / Radio

Email

Other:

Have you previously applied for a grant from The Bundle of Joy Fund? Yes No

If yes, when?

What is the total projected cost of treatment?

Reference the treatment estimate provided by the partnering fertility clinic's financial department.

How much funding are you requesting?

Refer to the treatment estimate provided by the partnering fertility clinic prior to answering.

If selected, what amount can contribute to the cost of treatment?

This includes personal contributions, loans, and crowd sourcing (GoFundMe, etc.). Refer to the treatment estimate provided by the partnering fertility clinic prior to answering.

Background

Applicant 1

Legal Name:

Age:

Date of Birth:

Email Address:

Phone:

Physical Address:

City:

State:

Zip:

Current Employer:

Job Title:

Length of Employment:

Annual Salary (before taxes):

Married? Yes No | If yes, how long?

Children? Yes No | If yes, how many?

Are you an active or retired member of the military? Yes No

Do you use tobacco products? Yes No

Have you ever been arrested? Yes No | If yes, please attach an explanation. Failure to do so will result in disqualification.

Do you have insurance / employer sponsored support to support the cost of fertility treatment?
Yes No Incomplete Coverage

Are you related to anyone affiliated with Kyle Busch Motorsports or The Bundle of Joy Fund? Yes No

If yes, who?

Applicant 2

Legal Name:

Age:

Date of Birth:

Email Address:

Phone:

Physical Address:

City:

State:

Zip:

Current Employer:

Job Title:

Length of Employment:

Annual Salary (before taxes):

Married? Yes No | If yes, how long?

Children? Yes No | If yes, how many?

Are you an active or retired member of the military? Yes No

Do you use tobacco products? Yes No

Have you ever been arrested? Yes No | If yes, please attach an explanation. Failure to do so will result in disqualification.

Do you have insurance / employer sponsored support to support the cost of fertility treatment?
Yes No Incomplete Coverage

Are you related to anyone affiliated with Kyle Busch Motorsports or The Bundle of Joy Fund? Yes No

If yes, who?

Fertility History & Background

Name of partnering fertility clinic:

Who is your doctor at the partnering fertility clinic?

How long have you been a patient at the partnering fertility clinic?

What is the date of your last appointment at the partnering fertility clinic?

What is your infertility diagnosis?

How long have you been trying to conceive?

Have you ever been pregnant? Yes No | If yes, when?

What procedure(s) is needed?

IVF

IVF with Genetic Testing

IVF with Donor Sperm / Egg / Embryo

Other

What is your timeline to start treatment?

Have applicant 1 or 2 previously received infertility treatments or procedures at the partnering fertility clinic?

Yes No

If yes, please list all treatments including stimulation medications, IUI, IVF, etc. with dates and results.

Are you doing genetic testing (CCS, PGS, PGD)? Yes No

If yes, which test(s)?

Are you using an egg donor? Yes No

Are you using a sperm donor? Yes No

Are you using an embryo donor? Yes No

Are you using a gestational carrier? Yes No

Please include any additional information relevant to your history of infertility.

Health Insurance

Does Applicant 1 or Applicant 2 have insurance / employer sponsored support to support the cost of fertility treatment, including diagnosis, medication and / or treatment? Yes No Incomplete Coverage

If you answered yes or incomplete coverage, please describe your benefits, deductible, maximum out of pocket including what is covered and what is not covered.

If your insurance covers any type of infertility treatment, what benefits have you received to date?

If your insurance covers any type of infertility treatment, what benefits remain to date? Please include specific benefits and dollar amounts.

Does Applicant 1 or 2 have prenatal coverage? Yes No Incomplete Coverage

Does Applicant 1 or 2 have coverage for dependents? Yes No Incomplete Coverage

If you answered yes or incomplete coverage to either question, please explain.

Financial Information

Gross total annual household income:
Combine gross income (before taxes), plus any supplemental revenue earned by Applicant 1 and Applicant 2.

How much have you spent on infertility out-of-pocket to date?
Total should include all past expenses including diagnosis, medication, and treatment.

Have you taken any personal loans / used credit cards to pay for infertility treatment(s)? Yes No

If yes, what amount?

≠Are you current paying these accounts? Yes No

If yes, what is the balance due and monthly payment?

Have you received any other financial assistance? Yes No
This includes crowd sourcing (GoFundMe) etc.

Have you applied for or received financial assistance from any other organization? Yes No
This includes Livestrong Fertility, BabyQuest, Cade Foundation, etc.

If yes, please elaborate.

Please outline all monthly household income earned by Applicant 1 and Applicant 2 after taxes and withholdings.

Salary / Wages:

Self-Employment Income:

Overtime / Commission / Bonuses:

Dividends / Interest:

Trusts / Annuities:

Pension / Retirement Funds:

Disability / Unemployment or Workers Comp Insurance:

Public Assistance:
Welfare, etc.

Income Producing Property:

Other:

TOTAL MONTHLY INCOME:
Take-home after taxes and withholdings.

Please outline all monthly household expenses for Applicant 1 and Applicant 2.

Mortgage: or Rent:

HOA Fees:

Utilities:

Car Payment(s):

Phone(s):

Insurance:

Life Insurance / IRA:

Groceries:

Household Expenses / Services:

Clothing:

Entertainment / Eating Out:

Childcare / School:

Petcare:

Education Loans:

Credit Cards / Personal Loans:

Alimony:

Child Support:

Patrimony:

Medical Debts / Expenses:

Fertility Treatment:

Fertility Savings:

General Savings:

Charitable / Religious Giving:

Other:

TOTAL MONTHLY HOUSEHOLD EXPENSES:

What is the current balance of savings and checking accounts for Applicant 1 and Applicant 2?

Checking:

Savings:

What is the net worth of retirement / IRA savings plans for Applicant 1 and Applicant 2?

Applicant 1:

Applicant 2:

What is the current cash value of life insurance policies?

Applicant 1:

Applicant 2:

What is the current cash value of money market accounts or CDs?

Applicant 1:

Applicant 2:

Has Applicant 1 or Applicant 2 ever been in collections? Yes No

If yes, please explain in detail.

Treatment Estimate

Applicants must consult the partnering fertility clinic for a total projected cost of treatment and attach the official estimate to your application. Your application will be considered incomplete without inclusion of an official estimate and will be withdrawn.

Please outline a financial summary of your treatment plan.

Physician Fees:

Lab Fees:

Anesthesia:

Facility Fees:

Medication:

Genetic Testing:

Egg / Sperm / Embryo Donor:

Gestational Carrier Fees:

Other:

TOTAL PROJECTED COST OF TREATMENT:

Please provide an itemized budget to pay for your treatment.

Personal Contribution:

Insurance Benefits:

Financial Assistance:
This includes crowd sourcing (GoFundMe) etc.

Other Financial Grants:
This includes Livestrong Fertility, BabyQuest, Cade Foundation, etc.

Discounts:
This Compassionate Care Program, etc.

Other:

TOTAL AMOUNT OF GRANT REQUESTED:

Personal Impact Statement

Each applicant should prepare an independent personal impact statement. Please describe the significance of this grant award and how infertility has impacted your life. Applicants should include any extenuating circumstances (job loss, financial struggle, medical diagnosis, life changes, etc.) to be considered in addition to the information provided in this application.

Each statement should be 1,000 words or less and no more than two (2) pages, and include the applicant's signature, printed name, and date. Typed statements are preferred.

Photos are welcomed, but please submit copies, as photos will not be returned.

Personal Statement, Applicant 1

I attest I wrote this statement myself and was truthful in my explanation.

Signature ____

Name ____

Date ______________

Personal Statement, Applicant 2

I attest I wrote this statement myself and was truthful in my explanation.

Signature ____

Name ____

Date ______________

Surprise Grant Reveal Contact

Should you be awarded a grant award from The Bundle of Joy Fund, you consent to the following individuals being contacted on your behalf to plan a surprise grant reveal. Please ensure that your chosen grant reveal contact knows they may be contact by The Bundle of Joy Fund in the event you are selected for a grant award.

Grant reveals may be in person, virtual or come via a personalized video message.

Grant Reveal Contact 1

Name:

Relationship to Applicant(s):

Phone:

Email:

Grant Reveal Contact 2

Name:

Relationship to Applicant(s):

Phone:

Email:

Consent

By submitting this application and signing below, the applicant(s) understand and consent to the following:

Initial each statement and sign below.

1. I do herby give The Samantha and Kyle Busch Bundle of Joy Fund, its agents and assigns, full permission, and authority to use, publish and display my name, voice and photograph or other likeness for advertising, promotion, charitable solicitation, or other related promotional purposes in any media without compensation. Concessions can be made on a case-by-case basis.

Applicant 1: ________

Applicant 2: ________

2. Submission of this application does not in any way guarantee that I will receive a grant award from The Samantha and Kyle Busch Bundle of Joy Fund.

Applicant 1: ________

Applicant 2: ________

3. I understand that if selected for a grant award I will not receive any money directly. All funding will be provided directly to the partnering fertility clinic as a credit to my account.

Applicant 1: ________

Applicant 2: ________

4. I acknowledge that the application review committee will receive my personal, medical, and financial information and I am assured that this information will no be shared with any third parties outside of the review committee.

Applicant 1: ________

Applicant 2: ________

5. If I receive a grant award from The Samantha and Kyle Busch Bundle of Joy Fund, my funding must be used at the partnering fertility clinic within 12 months of receipt of the donation.

Applicant 1: ________

Applicant 2: ________

6. Should a refund be issued due to treatment costing less than estimated, services not being rendered, or as a result of a tax refund for adoption, I understand that refunds will be returned to The Samantha and Kyle Busch Bundle of Joy Fund and that I, the applicant, shall not be entitled to any direct compensation or refund outside of treatment needs.

Applicant 1: ________

Applicant 2: ________

7. If it is determined that any information contained in this application was falsified, if the instructions were not followed or if your family, fertility, or legal status changed following the submission of this application and The Samantha and Kyle Busch Bundle of Joy Fund was not notified of such a change, grant award funding, if offered, may be rescinded, or forfeited depending on the specific circumstance at the discretion of the review committee.

Applicant 1: ________

Applicant 2: ________

8. The Samantha and Kyle Busch Bundle of Joy Fund has the right to confirm that an applicant is in good standing with the partnering fertility clinic.

Applicant 1: ________

Applicant 2: ________

9. I acknowledge that I may be subject to a criminal background check as a prerequisite to receive funding from The Samantha and Kyle Busch Bundle of Joy Fund.

Applicant 1: ________

Applicant 2: ________

10. The information contained in this application is truthful.

Applicant 1: ________

Applicant 2: ________

11. I acknowledge that The Samantha and Kyle Busch Bundle of Joy Fund and its agents are released from any liability arising from this grant application or its partnership with the health care provider. This release includes but is not limited to claims, demands, causes of actions, damages, costs, judgments, and expenses.

Applicant 1: ________

Applicant 2: ________

12. I acknowledge that The Samantha and Kyle Busch Bundle of Joy Fund is in no way responsible for the performance and outcome of any medical treatment that I may receive with the grant provided by The Samantha and Kyle Bush Bundle of Joy Fund and that the election of health care provided is my sole decision.

Applicant 1: ________

Applicant 2: ________

Applicant 1 Signature/Date: ____

Applicant 1 Name: ____

Applicant 2 Signature/Date: ____

Applicant 2 Name: ____

Medical Authorization

Patient Authorization for Use and Disclosure of Protected Health Information

By signing below, I authorize   to disclose certain health information about me to The Samantha and Kyle Busch Bundle of Joy Fund.

This authorization permits the above-mentioned partnering fertility clinic to disclose health information about me, and my partner, if applicable, for the purpose of applying for a grant award from The Samantha and Kyle Busch Bundle of Joy Fund.

Partnering Fertility Clinic:

Address:

Physician:

Applicant 1 Signature/Date: ____

Applicant 1 Name: ____

Applicant 2 Signature/Date: ____

Applicant 2 Name: ____