



## FACE SHEET

Please type or clearly print

Applicant #1 name: \_\_\_\_\_ Applicant #2 name: \_\_\_\_\_

State: \_\_\_\_\_

Home Phone \_\_\_\_\_

Alternate Phone #1 \_\_\_\_\_

Alternate Phone #2 \_\_\_\_\_

Mailing Address \_\_\_\_\_

Email address: \_\_\_\_\_

How much money are you requesting? (cannot exceed \$10,000) \_\_\_\_\_

What will the grant be used for? (Check which one applies)

\_\_\_\_ Adoption      \_\_\_\_ Fertility Treatment

If Fertility Treatment: will grant money be used for egg donation? Yes \_\_\_\_ No \_\_\_\_

If Fertility Treatment: will grant money be used for surrogacy? Yes \_\_\_\_ No \_\_\_\_

What is the name of your adoption agency or clinic? \_\_\_\_\_

Who is your doctor (fertility clinic) or case manager (adoption)? \_\_\_\_\_

What is the address of your clinic or adoption agency? \_\_\_\_\_

What is the phone number of your clinic or adoption agency? \_\_\_\_\_



**Tinina Q. Cade Foundation *Family Building Grant Application***

Please complete this chart. (If an item does not apply to you, please put N/A).

	Applicant #1	Applicant #2
Name (Last, First)		
Date of Birth		
Age		
Email Address		
Current Job Title		
Employer's Name		
Dates of Employment		
How did you hear about the grant?		
If married, number of years married?		
Are you able to attend the Family Building Gala in MD on 11/4/17?		
If the answer above is "no"- why not?		
Do you currently have any children? <i>(please circle)</i>	Yes                      No If yes, how many? _____	Yes                      No If yes, how many? _____
Have you ever been arrested for: Misdemeanor?	Yes                      No	Yes                      No Yes                      No
Felony?  <i>If "yes" please explain in personal statement.</i>	Yes                      No	
(Optional) Race/ Ethnicity		

(2) Does either Applicant #1 or Applicant #2 have insurance/ employer sponsored support that will assist with the costs associated with fertility treatment/adoption? \_\_\_ Yes \_\_\_ No \_\_\_ Incomplete Coverage

If incomplete coverage, please describe what is covered and what is not covered:

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(3) Are you willing to volunteer at a TQCF activity or an activity for an organization that supports infertile families (in any location)?  Yes  No

If Yes, please describe how you would like to help: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(4) Do you have any previous experience with the Cade Foundation through volunteering or attending an event sponsored by the Cade Foundation?  Yes  No

If Yes, please describe your experience: \_\_\_\_\_  
\_\_\_\_\_

(5) Do you have any experience in general volunteering or fundraising?  Yes  No

If Yes, please describe your experience: \_\_\_\_\_  
\_\_\_\_\_



**Personal statement from Applicant #1:**

**Name:** \_\_\_\_\_

**Please submit a statement written independently by EACH applicant indicating 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 grant reviewers as they review your application for the *Family Building Grant*.

Limit: 500 words or less.

**Statement:**

I attest that I wrote this statement (signature) \_\_\_\_\_

(date) \_\_\_\_\_



**Personal statement from Applicant #2:**

**Name:** \_\_\_\_\_

**Please submit a statement from written independently by EACH applicant) indicating 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 grant reviewers as they review your application for the *Family Building Grant*. Limit: 500 words or less.**

**Statement:**

I attest that I wrote this statement (signature) \_\_\_\_\_

(date) \_\_\_\_\_



**HOUSEHOLD BUDGET --**

**Please complete the chart below to provide your family's monthly budget for a typical month.**

**Annual Household Income** (Including combined adjusted gross income: This should match Line 37 from IRS form 1040 plus other annual revenue of Applicant #1 and Applicant #2):

\$ \_\_\_\_\_

Expense	Average Cost/month
Mortgage/Rent	\$ _____
Car payment	\$ _____
Utilities	\$ _____
Credit Cards	\$ _____
Alimony/Patrimony	\$ _____
Day care	\$ _____
Phones	\$ _____
Education loans	\$ _____
Entertainment	\$ _____
Eating Out	\$ _____
Groceries:	\$ _____
Fertility treatment	\$ _____
Adoption savings	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____
<b>Total Monthly Expenses</b>	<b>\$ _____</b>

**Savings:**

What is your current total balance of savings and checking accounts?

Bank Name: \_\_\_\_\_ Savings #1 \_\_\_\_\_ Checking \_\_\_\_\_

Bank Name: \_\_\_\_\_ Savings #2 \_\_\_\_\_

What is the net worth of your retirement/IRA savings plan?

Applicant #1 \$ \_\_\_\_\_ Applicant #2 \$ \_\_\_\_\_

Do you own any stocks or bonds or have any other investments? If yes, please indicate the total portfolio value. Applicant #1 \$ \_\_\_\_\_ Applicant #2 \$ \_\_\_\_\_



**GRANT BUDGET PROPOSAL --**

**Please provide a proposed budget for how you will use the requested grant money along with your personal financial contribution. See "Sample Grant Budget Proposal" in the instruction packet.**

Please check one box::    Assist with costs of adoption                      Assist with costs of fertility treatment

**Amount of grant money requested (cannot exceed \$10,000): \$ \_\_\_\_\_**



Please upload **pages 1 and 2 only** of your signed tax documents (Form 1040) here. If there are 2 applicants both applicants and you file separately both must submit their tax documents. Tax documents must be for 2016 or 2017.

Example Do Not Submit





**Medical Information:** If you are seeking a grant for domestic child adoption do not complete the Medical History questions below. Instead please ask your physician to prepare a letter stating that you have infertility and to describe the cause if known. If you are seeking a grant for any form of fertility treatment including embryo adoption, donor egg and or donor sperm, IVF, IUI, gestational carrier – please complete the Medical History pages below.

**Medical History for Women (for fertility treatment grant applications only):**

Seeking grant for fertility treatment for the following: (check the appropriate):

\_\_\_ IVF    \_\_\_ Egg Donor    \_\_\_ IUI    \_\_\_ ICSI    \_\_\_ Other: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Medical History for Women (for fertility treatment grant applications only):**

Medical Problems: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you been told you have infertility? Yes No  
 Cause: \_\_\_\_\_

Have you ever been treated for cancer? Yes No Medications? \_\_\_\_\_

Surgical History: \_\_\_\_\_

What medications does patient take? \_\_\_\_\_

Do you smoke? If yes, how many packs per day? \_\_\_\_\_

Has patient used marijuana or used other illicit drugs? (please specify) \_\_\_\_\_

If "yes" -- when was last drug use? \_\_\_\_\_

What procedures and treatments has patient already undergone and at what cost?

Procedure/Date	Out of Pocket Costs	Amount Covered by Insurance



**Medical History for Men (for fertility treatment grant applications only):**

Seeking grant for fertility treatment for the following: (check the appropriate):

\_\_\_ IVF    \_\_\_ Egg Donor    \_\_\_ IUI    \_\_\_ ICSI    \_\_\_ Other: \_\_\_\_\_

Sperm Analysis:    Date: \_\_\_\_\_    Count: \_\_\_\_\_    Motility: \_\_\_\_\_    Morphology: \_\_\_\_\_

Medical Problems: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you been told you have infertility?    Yes    No  
 Cause: \_\_\_\_\_

Have you ever been treated for cancer?    Yes    No    Medications? \_\_\_\_\_

Surgical History: \_\_\_\_\_

What medications do you take? \_\_\_\_\_

Do you smoke? If yes, how many packs per day? \_\_\_\_\_

Have you used marijuana or used other illicit drugs? (please specify) \_\_\_\_\_

If "yes" -- when was your last drug use? \_\_\_\_\_

What procedures and treatments have you already undergone and at what cost?

Procedure/Date	Out of Pocket Costs	Amount Covered by Insurance



**CONSENT**

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

- 1) To having our names and photographs published and released by the Tinina Q. Cade Foundation if we are awarded a Tinina Q. Cade Foundation *Family Building Grant* and described in that press release as recipients of the Tinina Q Cade Foundation *Family Building Grant* \_\_\_\_\_ (initial) \_\_\_\_\_ (initial)
- 2) Submitting this application does not in any way guarantee that we will receive a *Family Building Grant*. \_\_\_\_\_ (initial) \_\_\_\_\_ (initial)
- 3) We will not receive any money directly; the grant award will be provided directly to the service providers (fertility clinic, adoption agency, pharmacy, or other related parties). \_\_\_\_\_ (initial) \_\_\_\_\_ (initial)
- 4) The grant reviewers will be receiving personal medical and financial information and this information will not be shared with anyone outside of the Selection Committee. \_\_\_\_\_ (initial) \_\_\_\_\_ (initial)
- 5) If we are awarded a Family Building Grant that the money must be used within 12 months of the grants commencement date (August or January) for the purposes which it was requested, and that any unused funds will be returned to the Tinina Q. Cade Foundation general fund. \_\_\_\_\_ (initial) \_\_\_\_\_ (initial)
- 6) Should a refund be available due to services costing less than anticipated, services not being rendered, a shared risk cycle is unsuccessful and funds are reimbursed by a clinic or as a result of a tax refund for adoption, that the refund (up to the value of the grant award) will be returned to the Tinina Q. Cade Foundation and that we (applicants) shall not be entitled to any direct compensation or refund until the Tinina Q. Cade Foundation has been refunded the value of the grant provided. \_\_\_\_\_ (initial) \_\_\_\_\_ (initial)
- 7) If it is found 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 grant and the Cade Foundation was not notified of such a change, the grant money, if offered, may be rescinded or forfeited at the discretion of the Board of Trustees. \_\_\_\_\_ (initial) \_\_\_\_\_ (initial)
- 8) The Cade Foundation has the right to confirm that applicants are in good standing with their fertility clinic or adoption agency . \_\_\_\_\_ (initial) \_\_\_\_\_ (initial)
- 9) The information contained in this application is truthful. \_\_\_\_\_ (initial) \_\_\_\_\_ (initial)

\_\_\_\_\_  
Applicant #1 Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant #2 Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date



Please upload a photograph below.

