The Hadwin Family Foundation

Male Factor Infertility Fund Application

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Introduction and Instructions

The Hadwin Family Foundation Male Factor Infertility Fund was developed to directly assist individuals and families with the barriers associated with male factor infertility testing, diagnosis, and treatment. Unfortunately, infertility has a longstanding social stigma attached to it which is even more prominent when diagnosing and treating male factor infertility. In addition to the social stigma that still surrounds diagnosis and treatment, families are far too often further burdened by the cost of diagnostic testing, treatment options, and access to a qualified male factor infertility specialist.

Our goal at The Hadwin Family Foundation has always been to provide the most access to family building grants and avenues as possible, and we are honored to be able to offer the Male Factor Infertility Fund (MFIF) in partnership with The Center for Reproductive Medicine (CFRM) and Dr James Gilbaugh to the Kansas community. Dr. Gilbaugh is a board-certified urologist who is fellowship trained in male reproductive medicine and surgery. He has over 30 years of experience in treating male factor infertility and also has a passion for impactful philanthropic services.

The Male Factor Infertility Fund (MFIF) is currently only available to individuals with financial need who are prospective or current patients at the Center for Reproductive Medicine and require male factor infertility testing. Additionally, applicants must be legal, permanent residents of Kansas.

The MFIF provides crucial access to patients through a combination of services which include volunteer comprehensive exams with Dr Gilbaugh at CFRM as well as limited financial assistance for associated diagnostic testing through Heartland Pathology. At this time, the MFIF is awarded to two patients per year with applications submitted March 1st through March 31st via The Hadwin Family Foundation website only, www.thehadwinfamilyfoundation.org. Recipients will be selected and notified by March 7th.

Incomplete or untimely applications will not be reviewed and will be considered withdrawn from the grant cycle.

Please read the application carefully, fill it out truthfully and as completely as possible, and be sure to attach all required documents. You may be asked to provide proof of employment and income to verify your financial need, so please have your W-2s and personal income tax

documents ready and available. All insurance or employee benefit claims will be verified with a CFRM representative prior to any fund distribution.

All monetary funds allotted for diagnostic testing will be paid directly to Heartland Pathology and will be restricted to necessary diagnostic testing only as determined by Dr Gilbaugh. Funds will be awarded only for fees not yet received or incurred and cannot be applied retroactively. We hope to be able to expand coverage to limited surgical interventions in the future, but at this time these services are not covered by the Foundation. If Dr Gilbaugh determines a procedural or surgical intervention is necessary, this will be at the cost of the patient should they choose to proceed.

The Foundation does not discriminate based on race, religion, ethnicity or national origin, age, or sexual orientation, and all timely, complete applications will be considered. If you apply and are not selected as a fund recipient, you may apply for the fund in another application cycle, however you will be required to submit a full application each time.

If you have application specific questions, please email The Hadwin Family Foundation at info@thehadwinfamilyfoundation.org. For any medical questions regarding your infertility diagnosis and medical criteria, please contact your physician or representative at CFRM. Other than the medical criteria verification form, please do **not** provide medical records to the Hadwin Family Foundation.

Lastly, and most importantly, thank you for applying for the MFIF and trusting us to review your application. We know firsthand the toll that infertility testing, diagnosis, and treatment can have on a family. Every member on our selection committee has personally dealt with infertility as well as been through IVF treatment. We truly hope that the MFIF helps alleviate some of the burden for you and your family as you navigate your own infertility journey.

The Hadwin Family Foundation

Male Factor Infertility Fund (MFIF)

General Information

Full legal name: _____

Date of Birth: _____ Age: _____

Address: _____

_____

_____

Phone (cell): _____

Email: _____

Have you ever applied for the Male Factor Infertility Fund (MFIF)? If yes, when: _____

_____

How did you hear about the MFIF? _____

Are you related to anyone affiliated with the Hadwin Family Foundation or the Center for Reproductive Medicine (CFRM)? If yes, who and what is the relation? _____

_____

Have you ever been a patient at the Center for Reproductive Medicine (CFRM)? If yes, who were you seen by and when: _____

_____

Medical Information

Who is your primary care physician: _____

When was you last primary care appointment: _____

Have you been seen by a urologist? If yes, please provide detail including who you were seen by, what your diagnosis was, and when you were last seen: _____

_____

_____

_____

Were you referred to the Center for Reproductive Medicine? If yes, by who: _____

_____

How long have you been trying to conceive: _____

Number of current biological children: _____

Have you ever been diagnosed with male factor infertility? If yes, please provide details: _____

_____

_____

_____

_____

Have you had a semen analysis? If yes, when and did the results show any abnormalities: ____

_____

_____

_____

Have you had any hormonal testing? If yes, when and what were the results? _____

_____

_____

_____

Background Information

Who is your employer: _____

Job title: _____ Annual salary: _____

How long have you been employed here? _____

Are you married? If yes for how long: _____

Are you active or retired military? _____

Have you ever been arrested? If yes, please explain: _____

_____

Have you ever been convicted of a felony or misdemeanor? If yes, please explain: _____

_____

Do you have insurance coverage or employer support for infertility testing or treatment? If yes, please detail coverage including past benefits used and benefits remaining: _____

_____

_____

_____

_____

Personal Statement

Please submit a separate personal statement detailing any pertinent history relating to male factor infertility and your journey so far to becoming a parent. Personal Statements should be typed and uploaded as separate attachments. Please limit each personal statement to one to two paragraphs. Personal statements must include printed name, signature, and date.

Confirmations and Commitments

The submission of this application, my initials at each statement, and signature below, is my legal acknowledgement that I understand, agree with, commit to and confirm as true the following:

1. I am a prospective or current patient at the Center for Reproductive Medicine (CFRM) requiring male factor infertility assessment.

   _____ Applicant

2. I am a permanent legal resident of Kansas.

   _____ Applicant

3. All information provided in this grant application, including my typed personal statement, was written by myself and is truthful.

   _____ Applicant

4. If there is any change in status regarding any part of my application, I will notify the Foundation as soon as possible after I become aware of the change. Failure to immediately notify the Foundation may, at the discretion of the Foundation, disqualify me as a recipient, may cause any grant award to be rescinded, or lead to further actions.

   _____ Applicant

5. If I am selected to receive the Male Factor Infertility Fund, the Foundation shall pay the grant funds directly to Heartland Pathology for my benefit and such funds shall be applied only to diagnostic testing determined necessary by CFRM, with no grant funds paid to or due to me; provided however, any tax documentation required for such grant will be issued to me directly and any taxes applicable to or due by me because of the grant are my sole responsibility.

   _____ Applicant

6. If I am selected to receive the Male Factor Infertility Fund it (a) will be applied only to diagnostic testing determined necessary by CFRM, (b) will not exceed $1,500, and (c) to the extent not applied as stated or used in whole, will be refunded to the Foundation.

   _____ Applicant

7. All funds must be used in full within one year following the date of the Foundation's notification of selection to a fund recipient, and any funds not so used shall be refunded to the Foundation, unless the Foundation determines, in its discretion, that extenuating circumstances exist and provides written extension of the one-year period.

   _____ Applicant

8. Funds are awarded for use only in diagnostic testing at Heartland Pathology determined necessary by CFRM, and if for any reason diagnostic testing must be terminated, or is not completed, any remaining funds shall be refunded to the Foundation and will no longer be available to the recipient; provided, the Foundation may agree, in its discretion, to a written modification of this restriction.

   _____ Applicant

9. In reviewing my application, the Foundation will be reviewing the personal, medical, financial, and other information that I have voluntarily submitted as part of my application, and I have the expectation that such information will not be shared with anyone outside of the Foundation, CFRM, or their respective professional advisors.

   _____ Applicant

10. If I am selected as a fund recipient and subsequently receive any reimbursement payment(s) from an insurance provider, employer or other source for the fees covered by a fund, I shall immediately notify the Foundation of the amount of such payment, and remit that amount to the Foundation so it may be used for future grant funds.

    _____ Applicant

11. CFRM has my authorization to provide to the Foundation a written verification that I am a prospective or current patient at CFRM requiring male factor infertility assessment, and I shall provide any necessary authorization.

    _____ Applicant

12. If requested by the Foundation, I will submit to a background check as an additional part of the application and submit any necessary consents or information to complete such a background check, and my refusal to do so constitutes a withdrawal of my application.

    _____ Applicant

13. If selected as a fund recipient, I consent to having my name and photo published and/or released by The Hadwin Family Foundation as publicity of, and promotion for, the Male Factor Infertility Fund.

    _____ Applicant

14. Submission of this application and my agreement to all the terms and conditions does not in any way guarantee my selection as a fund recipient

    _____ Applicant

15. If asked, I will provide proof of employment and income, including, but not limited to, submission of W-2's and personal tax returns.

    _____ Applicant

_____

Signature/Date Applicant

_____

Printed Name Applicant

The Hadwin Family Foundation Authorization Form

Male Factor Infertility Fund

I authorize the Center for Reproductive Medicine (CFRM) to provide written verification to the Hadwin Family Foundation that I am a prospective or current patient at CFRM requiring male factor infertility assessment. I authorize the Hadwin Family Foundation to verify all insurance and employee benefit claims with an CFRM representative.

Clinic Name: Center for Reproductive Medicine (CFRM)

Address: 9300 E 29th St N, Ste 102. Wichita, KS 67226

Physician: _____

_____

Signature/Date Applicant

_____

Printed Name Applicant

The Hadwin Family Foundation Verification Form

Male Factor Infertility Fund

Grant Applicant Name: _____

Grant Applicant's Date of Birth: _____

I verify that the above forementioned applicant is a prospective or current patient at the Center for Reproductive Medicine (CFRM) requiring male factor infertility assessment. I, or a CFRM representative will verify all insurance and employee benefit claims with The Hadwin Family Foundation prior to any funds being distributed on behalf of the above forementioned applicant should they be selected as the fund recipient.

_____

Signature Date

_____

Printed Name

_____

Title/Position of CFRM Representative