Billings Clinic Foundation

Billings Clinic Miracle Fund Scholarship

Billings Clinic Reproductive Endocrinology in collaboration with the Billings Clinic Foundation has established a Miracle Fund for patients who have been diagnosed with fertility issues and need the assistance of in vitro fertilization in order to become pregnant. In this packet you will find the application form and other material needed to request for IVF funds.

Certain criteria have been established for consideration. The criteria include the following:

- A confirmed diagnosis of infertility and the need to undergo IVF to become pregnant.
- Current evaluation of both parents by REI physician with the conclusion of a good prognosis (good chance IVF will be successful, and woman is fit to carry pregnancy).
- Both partners need to be citizens of the United States and residents of Montana, Wyoming, North Dakota, or South Dakota.
- Total combined household income equal to or less than $120,000/y*ear*
- Agree to a background check through the submittal of this application.

Please include the following information with your completed application to be considered for these funds:

- Application
- Personal statement from each partner
- Tax returns for both partners for the last two years
- Copy of Driver's License or Passport
- Signed Release of Information

Please submit all documentation that will be kept confidential to the following address

Billings Clinic Foundation
Miracle Fund
2917 10th Ave N • Billings, MT 59101

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MIRACLE FUND APPLICATION

Application Date: Choose from the dropdown: Married

APPLICANT INFORMATION

Legal Name (First, Middle, Last)

Email: Home Phone: Cell Phone:

Current Address:

City: State: Zip Code:

SSN: Date of Birth: Sex: Female

Do you currently have children? Yes If Yes. How many?

Health Insurance Name: Phone:

Does your plan cover fertility treatments? Yes Describe coverage:

EMPLOYMENT INFORMATION

Current Employer:

Employer Address: How long?

Phone: E-mail: Fax:

City: State: Zip Code:

Occupation: Annual Income:

PARTNER INFORMATION

Legal Name (First, Middle, Last):

Email: Home Phone: Cell Phone:

Current Address:

City: State: Zip Code:

SSN: Sex: Male

Do you currently have children? Yes If Yes. How many?

Health Insurance Name: Phone:

Does your plan cover fertility treatments? Yes Describe coverage:

EMPLOYMENT INFORMATION (PARTNER)

Current Employer:

Employer Address: How Long?

Phone: E-mail: Fax:

City: State: Zip Code:

Occupation: Annual Income:

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Personal Statement

Name: _____

Please submit an independent statement from each partner explaining the importance of this donation as it relates to your family and family building goals. Please include any extenuating circumstances, such as financial struggle, job loss, etc. That should be taken into consideration. This statement, along with your application will be taken into consideration by the Miracle Fund Board. Please limit the statement to 1000 words.

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Statement of Attestation

I/We declare the information in this application and supporting documents is the full truth to the best of our knowledge. We understand by submitting this application, it does not guarantee we will receive any assistance from the Miracle Fund. We understand any money we are awarded will be passed directly to the Billings Clinic as payment for IVF. We will not receive any money directly. In addition, should the IVF cycle be cancelled, or any money is remaining, for any reason, that money will go back to the Miracle Fund. We understand any assistance we receive must be used within 12 months and can only be used as directed by the board, either for IVF or a frozen embryo transfer, depending on our circumstances. The IVF cycle will consist of one fresh IVF cycle (including a conversion cycle with subsequent FET) or FET cycle should we have embryos already frozen. Decisions regarding the number of embryos transferred will be made by our REI physician under the direction of the ASRM guidelines. We acknowledge any information provided to the board members is for decision making purposes only and will not be shared in any way outside of the board.

Patient Signature:_____Date:_____

Patient Signature:_____Date:_____