NYS Demonstration Infertility Project Application

Please complete this form and return to: NYU Langone Fertility Center, Attn: Grant Coordinator
660 First Avenue, 5th Floor
New York, NY 10016

Female Patient Name (Last, First, MI)

Street Address | City | State | Zip

Home Telephone ☐ Preferred | Alternate Telephone ☐ Preferred

Are you a Legal Resident of NY State?
☐ Yes ☐ No *If no, you are not eligible*

Date of Birth (*women 21-44 years of age are eligible)*

Please provide a copy of all the required documentation for yourself and your co-applicant/partner:

Copy of Driver's license or passport to verify Date of Birth ☐ Attached
Are you covered by commercial medical insurance? ☐ Yes ☐ No *If no, you are not eligible*
Have you exhausted your in and out of network IVF benefits? ☐ Yes ☐ No ☐ I do not have in or out network IVF benefits
Are you covered by Medicaid/FHP or Medicare ☐ Yes ☐ No *If yes, you are not eligible for the grant*
Please provide a copy of insurance card(s) ☐ Attached
Do you have a prescription plan? ☐ Yes ☐ No
Please provide a copy of prescription card(s) ☐ Attached
Have you been diagnosed as infertile? ☐ Yes ☐ No *If yes, please provide contact information*
Doctor's Name | Address | Telephone

Please check medical issues that apply to you:

☐ I am less than 30 years old and have failed to conceive after 1 year of unprotected intercourse.
☐ I am 30 years of age or older and have failed to conceive after 6 months of unprotected intercourse.

Have you been diagnosed with tubal disease? ☐ Yes ☐ No
If yes, provide a copy of the HSG report or surgical report listing a diagnosis of tubal disease/obstruction.

Please check any that apply to you:

Documented history of oligo/amenorrhea? ☐ Yes ☐ No
Irregular periods? ☐ Yes ☐ No
Endometriosis? ☐ Yes ☐ No
History of in-utero DES Exposure? ☐ Yes ☐ No
Pelvic pain? ☐ Yes ☐ No
Pelvic inflammatory disease? ☐ Yes ☐ No
Does your infertility stem from male factor? ☐ Yes ☐ No *If yes, provide your partner's most recent semen analysis*

Your most current FSH level: Date of FSH Results:

Have you had 4 or more cycles of Ovulation Induction (clomiphene, etc.) with or w/o IUI? ☐ Yes ☐ No
Do you have any medical condition that would contraindicate a pregnancy? ☐ Yes ☐ No
If yes, indicate the condition: ____

Have you participated in the NYS Infertility Grant at any program prior to this application? ☐ Yes ☐ No
If yes, indicate where: ____
Have you had IVF that was unsuccessful- i.e. no pregnancy or no live birth? ☐ Yes ☐ No If yes, how many: __________
Have you had IVF that resulted in a live birth? ☐ Yes ☐ No If yes, how many: __________
Have you had IVF cycles that were cancelled (did not go to retrieval or to transfer) ☐ Yes ☐ No If yes, how many: __________
Are you currently a patient at the NYU Langone Fertility Center? ☐ Yes ☐ No If yes, Dr. ______________________________________

What was your **total household income for 2019?** **$**________________________

You must provide a copy of your signed NYS and Federal Tax return for 2019. Both partners' returns must be attached for consideration. You must provide tax returns for the year in which you receive assessment and/or treatment services from the NYU Langone Fertility Center. Additional information may be required for your application.

I understand that there is patient co-pay for this project that I must turn over all insurance EOBs & insurance payments directly to NYULFC for applicable services. All treatments must be concluded prior to funding being exhausted and/or prior to the expiration of the contract on 9/30/20. My cycle may be cancelled if either of these items occurs. An application does not guarantee participation as funding or timing issues may prevent participation. By signing below we certify that all information as provided on this form is correct and true.

Signature (Female Patient) Date | Signature (Partner) Date