**PLEASE TYPE DIRECTLY INTO THIS FILE. DO NOT HANDWRITE.**

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| **Personal Information** |
| **Applicant 1** Name (Primary contact): |
| Date of birth:  | SSN: | Phone:  |
| Email: |  |  |
| Current address: | Number of people in household: |
| City: | State: | ZIP Code: |
| Own Rent (highlight) | Monthly payment/rent: | How long? |
| Previous address: |
| City: | State: | ZIP Code: |
| Owned Rented (highlight) | Monthly payment/rent:  | How long? |
| Children: | Do you smoke? Yes/No (Highlight) |
| Years married? (for same sex couples, years of relationship): |
| Where you raised Jewish? Yes/No (Highlight) |
| Do you consider yourself Jewish now? Yes/No (Highlight) |
| Highest degree earned: High School/Assoc./ Bach/ Graduate/ Post Grad (highlight) |
| Have you ever been convicted or pled guilty to a felony or misdemeanor? Y/N |
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| **Applicant 2 Name**: |
| Date of birth: | SSN: | Phone: |
| Email: |
| Previous address: |
| City: | State: | ZIP Code: |
| Owned Rented (circle) | Monthly payment/rent: | How long? |
| Children: | Do you smoke? Yes/No (Highlight) |
| Where you raised Jewish? Yes/No (Highlight) |
| Do you consider yourself Jewish now? Yes/No (Highlight) |
| Highest degree earned: High School/Assoc./ Bach/ Graduate/ Post Grad (circle) |
| Have you ever been convicted or pled guilty to a felony or misdemeanor? Y/N |

Our goal is to build Jewish families and remove barriers to infertility treatment. Please attach a personal statement to help us learn more about you, including the following: personal background, summary of your infertility experience, financial implications of treatment, and your vision for raising your children Jewish if treatment is successful (**800 words max**). Because the application committee will review your application and we may share parts of your story for publicity, writing in a manner to keep your identity anonymous (not using names) is acceptable. You may also have a friend, rabbi or other Jewish professional leader submit a letter of reference to Hasidah (encouraged).

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| **Financial Information** |
| Applicant 1 Employment Information |
| Current employer: |
| Employer address: | How long? |
| Phone: | E-mail: | Fax: |
| City: | State: | ZIP Code: |
| Position: | Hourly or Salary (highlight) | Annual income: |
| Applicant 2 Employment Information |
| Current employer: |
| Employer address: | How long? |
| Phone: | E-mail: | Fax: |
| City: | State: | ZIP Code: |
| Position: | Hourly or Salary (highlight) | Annual income: |
| Credit Cards |
| Name | Balance | Monthly payment |
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| Loans (Auto, student, home, etc) |
| Loan type | Balance | Monthly payment |
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| Other Debts, or Obligations |
| Description | Balance | Monthly Payment |
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| **Financial Information (cont)** |
| Mortgage/RENT |
| Description | Balance | Monthly Payment |
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| Additional Expenses |
| Previous Infertility Treatment & other extraordinary expenses | Date (s) |
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| Assets  |
| Description (Savings, checking, money market, life insurance, car, stocks, retirement, etc) | Value |
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| other Sources of Income |
| Description (Dividends, disability, unemployment, workers comp, property rental, etc) | Amount per month or value |
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| Have you ever filed bankruptcy? Y/N (highlight) | Foreclosed on a home? Y/N (highlight) |
| Do you have family or friends who have provided or are able to provide financial assistance? |
| Additional information about your finances that we should know: |

Please attach proof of Income: last two IRS returns for both applicants and two most recent pay stubs

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| **Medical Information** |
| Please have your treating physician submit a completed medical form to Hasidah.  |
| If you have been seen by other clinics or have any additional relevant medical information, please describe/explain here:  |

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| Treatment Costs Please include all anticipated expenses (e.g. IVF, PGD, ICSI, anesthesia, Labs, Meds, Travel, etc.) |
| DESCRIPTION | Insurance: (circle) | Your Cost |
|  | Partial/None |  |
|  | Partial/None |  |
|  | Partial/None |  |
|  | Partial/None |  |
|  | Partial/None |  |
|  | Partial/None |  |
|  | Partial/None |  |
| Total: |  |
| Additional information about costs or insurance coverage: |
| Funding Request |
| Hasidah typically funds between $5,000 and $15,000. A personal contribution is required. You may request “up to” amounts if you are considering a combination of grants and loans. For loans, two co-signers are required and the information needed for processing a loan may be provided to Hasidah’s partner loan agency for approval purposes. Make sure the total below equals to the total treatment cost above. |
|  | Amount |
| Personal Contribution | $ |
| Assistance from other sources (please describe below) | $ |
| Grant Request | $ |
| Loan Request | $ |
| Total Request from Hasidah | $ |
| Total | $ |
| Funding Request Comments: |