Angels of Hope
Inc., NFP

Creating Miracles Grant Application

"Making a Difference One Life at a Time"

PERSONAL INFORMATION

Name: _____
Last First Middle

Name: _____
Last First Middle

Home Address: _____
Street Address Apartment #

_____
City State Zip

Home Phone: _____ Cell Phone: _____

Dates of Birth: _____ _____

Social Security Numbers: _____ _____

E-mail Address: _____

Date and Place of Marriage: _____

Children in your Household: _____
Name Date of Birth

_____
Biological Parents

_____
Name Date of Birth

_____

EMPLOYMENT INFORMATION (Please provide for the last five years)

Applicant One Employer: _____

Name of Current Employer | Date Employment Began

Street Address

City | State | Zip

Job Title | Work Telephone Number

Name of Previous Employer | Dates of Employment

Street Address

City | State | Zip

Job Title | Work Telephone Number

Attach an extra page if necessary to list employment history for the past 5 years.

Applicant Two Employer: _____

Name of Current Employer | Date Employment Began

Street Address

City | State | Zip

Job Title | Work Telephone Number

Name of Previous Employer | Dates of Employment

Street Address

City | State | Zip

Job Title Work Telephone Number

Attach an extra page if necessary to list employment history for the past 5 years.

EDUCATION (for each Applicant):

Applicant Education/Profession: _____

Last School Attended: _____ Date of Graduation: _____

Degree Earned: _____

Applicant Education/Profession: _____

Last School Attended: _____ Date of Graduation: _____

Degree Earned: _____

CRIMINAL BACKGROUND

Have you ever been convicted or pled guilty to a felony or misdemeanor? ___

If yes, on a separate piece of paper, please give the date of the offense, the charge, the place the incident occurred, and the outcome.

HEALTH INSURANCE INFORMATION

Primary Insurance Provider: _____
Name of Company

_____
Member Number Telephone Number

_____
Street Address

_____
City State Zip

Secondary Insurance Provider: _____
Name of Company

_____

Member Number Telephone Number

Street Address

City State Zip

Description of Fertility Insurance Coverage (Please also attach summary of benefits related to fertility treatment from your insurance policy and a photocopy of both sides of your insurance card):

MEDICAL INFORMATION (Please provide information regarding the physicians who have been treating you for fertility issues):

Physician's Name Telephone Number

Street Address

City State Zip

Diagnosis and Type of Treatment Received to Date

Physician's Name Telephone Number

Street Address

City State Zip

Diagnosis and Type of Treatment Received to Date

Have you ever been found to be HIV positive or diagnosed with a terminal illness? _____ If yes, please explain on an attached sheet.

PERSONAL REFERENCES

Please list two personal references not related to you and their phone numbers:

1. _____ _____
Name Telephone Number

_____
Street Address

_____
City State Zip

_____
How do you know this person?

2. _____ _____
Name Telephone Number

_____
Street Address

_____
City State Zip

_____
How do you know this person?

ADDITIONAL INFORMATION REQUIRED TO BE SUBMITTED WITH THIS COMPLETED APPLICATION FORM:

- A letter from your treating physician explaining the medical reasons for pursuing fertility treatments and the likelihood of success. This letter must include the details listed on the attached handout entitled "Physician's Letter."
- Write a narrative on a separate page regarding the personal and financial reasons for submittal of this application and how the grant money would be used. Include a description of any unusual financial or other circumstances that may affect our consideration of your application for financial assistance, including the extent of your own

financial contribution to date (attach a separate page if necessary) and your insurance coverage, complete the personal financial statement and make a copy of your most recent tax return and all attachments and submit with your application. On the following page you are asked how much financial assistance you are seeking. Understand that our grant monies are limited and our typical award is between $2500.00-$12,000.00. Please explain how you are prepared to pay the difference, if any, between the cost of the intended medical procedures and our financial assistance.

- Execute release forms for each employer, personal reference and treating physician. Make additional copies as necessary.
- A complete copy of your most recent tax return.

AMOUNT OF GRANT REQUESTED (amount potentially awarded will be in the discretion of our organization and based on the availability of funds):
$ _____

CERTIFICATION

We swear under oath that the information provided in this application is truthful and accurate. We give Angels of Hope, Inc., NFP permission to contact any individual or professional referenced in this application to verify the submitted information. We acknowledge receipt of the notice of privacy practices.

_____	_____
Signature of Applicant	Date
_____	_____
Signature of Applicant	Date

Please return this completed application along with the required attachments including a complete copy of your W-2s and last tax return to:

Angels of Hope, Inc., NFP
265 Richards Street
Coal City, Illinois 60416

You will be notified by telephone and in writing if you are selected as a grant recipient. Thank you for your time and interest in our grant program.