Amelia Molloy's Angels

Amelia Molloy's Angels ("Foundation") is an IRC § 501(c)(3) foundation committed to providing financial support and assistance for those struggling with infertility in the Kern County. The grants extended by Amelia Molloy's Angels will provide couples that do not have access or available fertility insurance nor the financial resources to pay for infertility treatments the opportunity to fulfill their dream of a family. Applicants will be asked to complete a confidential application including, but not limited to, a description of their infertility history, personal and familial situation, and financial need.

Eligibility:

In order to be considered for a grant, couples must, but not limited to, complete and submit an application for consideration; (2) provide a detailed history concerning their respective fertility related issues; (3) record a short video that describes themselves and what a fertility grant would mean to them and their family; (4) execute a waiver and release, as part of the application process, permitting the foundation to share their story via media outlets associated with the foundation if they are selected[1]; (5) if selected, execute a legal agreement with respect to the award, including financial support and assistance, to be provided. Applicants should also be able to demonstrate overall physical and mental health and well-being, and will be required to establish financial stability including, but not limited to, effective basic health insurance for mother/prenatal care, adequate living arrangements, and means for child support.

The family grant amounts available for potential disbursement will be dependent and contingent upon fundraising and other related efforts carried out, performed, and completed during the previous calendar year by the Foundation. While we would love to offer family grants to every applicant, not all applicants will be selected or receive family grants. The Foundation does not make any promises or representations that by submitting an application that an applicant will be selected or that applicant will receive family grant funding. Applicant selection and any award of family grant funding is conditional upon applicant meeting and satisfying all requirements set forth hereunder and to be presented. Only

[1] Specific, confidential medical history, diagnoses, and other related matters will not be included in any disclosure or dissemination without consent provided by the applicant(s), and will be narrowed in scope to medical information related to purposes of the grant. Confidential insurance information, financial disclosures, and other related information will in no manner be disclosed and confidentiality preserved. Refusal to consent to media disclosure and/or dissemination shall not result in the grant being declined or revoked, and all reasonable efforts will be taken to ensure confidentiality will be preserved. The Foundation and/or Applicant reserve the ability and opportunity to discuss and potentially agree upon other means or methods concerning publication and/or dissemination of personal or familial information related to the grant if selected.

upon satisfaction of all conditions will an applicant be confirmed as a family grant recipient and a funding award confirmed.

The family grant amounts will vary among the family grant recipients, and partial or full grants can and may be awarded.[2] What is covered (i.e. monitoring, lab work, medications, procedures, etc.) under the grant amount will be disclosed to each of the family grant recipient at time of award. Funds will be held in trust by the Foundation and will be paid directly to the clinic, facility, and/or medical provider selected, upon submission of invoice for services to the Foundation from the clinic, facility, and/or medical provider, to ensure that grants are utilized for the purposes set forth hereunder and in accordance with the mission of this Foundation.[3] The funds from the family grant will be available to the recipients for a period of twelve (12) months from the date that the family grant recipient is notified of the award. The period of utilization will not be extended except upon mutual agreement reached between the Foundation and family grant recipient. As set forth above, the grant can be used toward fertility and related treatments at any fertility clinic, facility, and/or medical provider of clients choosing.[4]

From all of us at Amelia Molloy's Angels, we thank you for your interest in the Foundation and application. Please know that all of us are here for you and your family, and should you ever have any questions, comments, or would like to discuss the application, availability of grants, or getting involved with the Foundation, please feel free to contact us at (661) 800-7096 or by e-mail at info@ameliamolloysangels.com.

Sincerely,

Ashley Antongiovanni, Mother to Amelia Molloy and Founder

[2] The Foundation reserves all rights and discretion to determine the total amount of the grant to be extended to each applicant selected as a recipient.

[3] The Foundation has contacts with clinics, facilities, and medical providers within the Kern County area. Should an applicant necessitate assistance in selecting a care provider, please feel free to reach out and we are happy to provide information.

[4] It should be noted that this is an Application for Receipt of Grant regarding fertility treatment and other related matters. At the time of selection, the Foundation reserves the right to present to recipient any further documentation, proposed agreements, and/or requests as may be necessary.

SUBMISSIONS CHECK LIST:

To apply for a Family Grant, you must submit the following information with your completed Application:

1. Complete Application. Write **N/A** (Not Applicable) if the question does not apply to you. Do NOT leave it blank.

2. A personal statement in the form of a short video form expressing and describing why you (and your spouse or partner) have chosen to apply for a family grant. What should be included: information about your efforts to conceive, any information you feel would be pertinent to your journey of infertility, why you feel you would be a worthy candidate, and any other information you feel we should know, understand, or consider as part of the grant application process.

3. Signed waiver and release form (below) giving Amelia Molloy's Angels permission to use your story, name, image, likeness, and other information related to your story and Application.

4. A copy of both sides of Applicant's and spouse's (or partner's) applicable insurance card(s).

5. Medical packet: Your physician or medical provider **MUST** complete the medical portion of the application (pages 8, 9, and 10). It is the Applicant's sole obligation and responsibility to obtain these pages form the physician and include them with the Application. An application is **NOT** complete without these forms, and will not be considered if Applicant fails to include.

6. **DO NOT SUBMIT ANY APPLICATION OR APPLICATION PAPERWORK WITHOUT REQUISITE SIGNATURES. FAILURE TO DO SO WILL RESULT IN YOUR APPLICATIOIN BEING DENIED OR RECEIPT AND CONSIDERATION THEREOF DELAYED.**

7. **ALL APPLICATIONS MUST BE SUBMITTED BY THE CLOSE OF BUSINESS (5:00 P.M. PST) BY NO LATER THAN THE GRANT DEADLINE. LATE SUBMISSIONS OR APPLICATIONS SUBMITTED PAST THE CLOSE OF BUSINESS ON THE GRANT DEADLINE WILL NOT BE ACCEPTED OR CONSIDERED.**

8. **ALL APPLICATIONS NEED TO BE SUMBITTED ONLINE THROUGH OUR WEBSITE, WHICH IS AS FOLLOWS: WWW.AMELIAMOLLOYSANGELS.COM. IF YOU ARE UNABLE TO SUBMIT AN APPLICATION ONLINE THROUGH OUR WEBSITE, PLEASE CONTACT US SO THAT WE CAN ARRANGE DELIVERY AND RECEIPT OF YOUR APPLICATION.**

APPLICANT APPLICATION

PERSONAL INFORMATION

("Applicant" refers to the person who will be receiving the family grant to go towards their IVF treatment, surrogacy or adoption process)

APPLICATANT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Street Address: _____
City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____

Work Phone: _____ Mobile Phone: _____

Email: _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security Number: _____-_____-_____

Occupation: _____

Employer Name and Phone: _____

Date Employment Began: _____ Salary: _____

Name of Previous Employer: _____

Dates of Employment: _____

Job Title at Previous Employer: _____

(Please provide at least 5 years of employment history. Please attach additional documentation to this application, if needed).

APPLICANT'S SPOUSE OR PARTNER INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Street Address: _____
City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____

Work Phone: _____ Mobile Phone: _____

Email: _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security Number: _____-_____-_____

Occupation: _____

Employer Name and Phone: _____

Date Employment Began: _____ Salary: _____

Name of Previous Employer: _____

Dates of Employment: _____

Job Title at Previous Employer: _____

(Please provide at least 5 years of employment history. Use additional paper, if needed).

CHILDREN LIVING IN YOUR HOUSEHOLD (part time and full time)

NAME	DATE OF BIRTH	BIOLOGICAL PARENTS

HOW MANY YEARS HAVE APPLICANT & APPLICANT'S PARTNER BEEN TOGETHER: _____

EDUCATION

Application's Education/ Profession: _____

Last School Attended: _____

Date of Graduation: _____ / _____ / _____ Highest Degree Earned: _____

Partner's Education/ Profession: _____

Last School Attended: _____

Date of Graduation: _____ / _____ / _____ Highest Degree Earned: _____

CRIMINAL BACKGROUND

Has the Applicant or Applicant's spouse or partner ever been convicted or pled guilty to a felony or misdemeanor? **YES or NO**

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

HEALTH INSURANCE INFORMATION

Primary Insurance Provider: _____

Name of Company Member # Phone #

_____

Address City State Zip

Primary Insurance Provider: _____

Name of Company Member # Phone #

_____

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(s)**).

_____
_____
_____
_____

If your insurance cover any type of infertility treatment, what benefits have you received up to this point?

_____
_____
_____
_____

MEDICAL INFORMATION

Please provide information regarding the physicians who have been treating you for fertility issues:

Physician's Name: _____

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

Diagnosis & Type of Treatment Received to Date: _____

_____

How long have you been attempting to conceive? _____

Has the applicant ever been pregnant? YES or NO If yes, how many times? _____

How many live births? _____ How many losses? _____

Does the applicant or the applicant's partner have any children at all? YES or NO

Has the applicant ever had any infertility procedures? YES or NO

If yes, please explain what the procedures have been, number of attempts, and outcomes:

_____

_____

Does the applicant have any frozen embryos? YES or NO If yes, how many and where are they kept? _____

With what physician(s) and/or clinic(s) have you been treated for infertility? _____

_____

_____

What type of treatment will the family grant be used towards (circle one): IVF / Surrogacy / Adoption

Video Statement (required):

Please upload a personal statement in a short video form (5-15 minutes) indicating why you (and your partner) have chosen to apply for our family grant. Include information about your efforts to conceive, give us any information you feel would be pertinent to your journey of infertility, and why you feel you would be a worthy candidate.

CERTIFICATION

We swear under oath that the information provided in this application is truthful and accurate. We give Amelia Molloy's Angels 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.

_____	_____	_____ / _____ / _____
Applicant's Name (print)	Applicant's Signature	Date
_____	_____	_____ / _____ / _____
Applicant's Partner Name (print)	Applicant's Partner Signature	Date

WAIVER AND RELEASE FORM

This Waiver and Release Form allows, authorizes, and permits Amelia Molloy's Angels to use your story, name, image, photograph, likeness, and/or other information and excerpts from your personal statement/video for purposes of providing information to other Applicants and persons potentially interested in becoming involved with the Foundation. It is the intent of the Foundation to use only information relevant to your story and Application for promotional, advertisement, and/or informational purposes. Foundation will engage to limit the scope of any disclosure and dissemination to matters relevant or related to the foregoing, and will undertake reasonable efforts to protect against the disclosure or dissemination of sensitive or confidential medical information or other matters that are not related or relevant thereto or the purposes of the intended publication.

The Applicant hereby assigns and grants Amelia Molloy's Angels and its directors, officers, employees, volunteers, agents, representatives, consultants, hers, successors, assigns, and all others working on behalf of or in a capacity for Amelia Molloy's Angels ("Team") the unlimited, irrevocable, and unrestricted right, permission, and ownership to use, copyright, publish, reproduce, exhibit, transmit, broadcast, digitize, and/or display excerpts, recordings, audiovisual materials, and other media visualizations, imaging, or information, in whole or in part, from the Applicant's personal statement and Application for editorial, trade, advertising, promotional, informational, and/or any other lawful purpose in any manner, form, format, and/or medium now existing or hereinafter created. Applicant agrees and acknowledges that the foregoing shall be the sole property of Amelia Molloy's Angels, and Applicant further agrees not to contest the rights or authorities granted hereunder. Applicant hereby waives any right to inspect or approve the recordings or media generated, copied, or created above. Applicant acknowledges and agrees that he and/or she shall not be entitled to compensation with respect to any use, publication, and/or dissemination of the foregoing.

The Applicant hereby releases, discharges and disclaims, and, as a result, shall save, hold harmless, and indemnify, Amelia Molloy's Angels and its Team from any and all claims, demands, liabilities, damages, penalties, and any and all other potential claims or causes of action related to the use of the foregoing or arising there out of or with respect thereto . Any person mentioned in the Applicant's personal statement/video shall be deemed to have consented to the use of their name, image, video, photograph, and/or likeness by Applicant and/or Amelia Molloy's Angels, and Applicant shall save, defend, hold harmless, and indemnify Amelia Molloy's Angels and its Team from and against any claims, demands, liabilities, damages, penalties, and any and all other potential claims causes of action that any of third-party mentioned or used in Applicant's personal statement/video may have and/or may or actually do assert against Amelia Molloy's Angels and its Team arising from or related to the use thereof. Surnames will **NOT** be used so as to protect the identification of any of the above.

_____ _____ / _____ / _____

Applicant's Signature Date

_____

Applicant Name (print)

_____ _____ / _____ / _____

Partner's Signature Date

_____

Partner's Name (print)

PERMISSION TO CONTACT

I give my permission for Amelia Molloy's Angels to contact my physician, care provider, and/or care provider's business manager.

_____ _____ / _____ / _____
Applicant's Signature Date

_____ _____ / _____ / _____
Partner's Signature Date

All information submitted to Amelia Molloy's Angels will be held in strictest confidence and viewed only by the selection committee. We thank you for your interest in Amelia Molloy's Angels and wish everyone of you the best in your attempt to build a family. No forms (photos, videos, letters, etc.) will be returned.

AUTHORIZATION FORM

Patient Authorization for Use and Disclosure of Protected Health Information
By signing, I authorize _____ (name of clinic) to disclose certain protected health information about me to Amelia Molloy's Angels.
This authorization permits the above mentioned clinic to disclose health information about me (and my partner, if applicable) for the purpose of applying for a family grant from Amelia Molloy's Angels.
Clinic Name: _____
Address: _____
Physician: _____
Patient's Signature: _____ Date: _____ / _____ / _____
Patient's Name (print): _____
Signature of Partner (if applicable): _____ Date: _____ / _____ / _____
Partner's Name (print): _____

THE FOLLOWING MUST BE COMPLETED BY YOUR PHYSICIAN:

MEDICAL EVALUATION:

PLEASE FEEL FREE TO ADD ANY STATEMENT IN SUPPORT OF THE PATIENT'S FAMILY GRANT REQUEST.

Patient Name: _____
Height: _____ Weight: _____ BMI: _____
Patient Age: _____ DOB: _____ Gravida _____ Para _____ Abortus _____
Partner's Age: _____ Does either smoke? YES or NO
Length of infertility (months trying): _____

Cause of infertility (choose all that apply):
Male Tubal/Uterine Ovarian Unexplained Pregnancy Loss
Other: _____

Prior Treatments:
Number of prior IUI's: _____ Outcomes: _____
Number of prior IVF's: _____ Outcomes: _____
# of eggs: _____ # fertilized: _____ # transferred: _____

Female Evaluation:
Medical Problems: _____
Current Medications: _____
Surgical History: _____
Ovarian Reserve: Day 3 FSH/ E2: _____ AMH _____ Antral Follicle Count: _____

Tubal/ Uterine

HSG Results: _____

Hydrosonogram: _____

Hysteroscopy: _____

Male Work-Up: Semen Analysis

Date: _____ / _____ / _____

Volume: _____ ml

Sperm Concentration: _____ million/ml

Motility: _____

Normal Morphology: _____ (indicate WHO or Kruger strict criteria)

What is your recommendation for treatment for this patient?

_____

_____

_____

_____

THIS FORM HAS BEEN COMPLETED BY:

Physician: _____

Clinic: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Dear Physician,

You have been given the enclosed medical form because your patient is applying for the Amelia Molloy's Angels family grant.

Amelia Molloy's Angels is a nonprofit charity founded in 2022. Our mission is to grant financial assistance to those struggling with the high costs of infertility treatments such as Invitro Fertilization, Surrogacy and the adoption process. Amelia Molloy's Angels award policy is to make up the gap between the total costs and what the patient can contribute. With this in mind, I am inquiring about the possibility of your providing a discount on services, whether this be a reduction in fees or a free treatment cycle.

Please note: You are obligated to honor the discount ONLY IF the patient is selected as an Amelia Molloy's Angels family grant recipient. (Please check one of the following circles):

- Our clinic would be willing to offer the grantee a $_____ grant.
- Our clinic would match the Amelia Molloy's Angels family grant up to a maximum of $_____.
- Our clinic would offer a grant of _____% of the total cost (physician's fee and lab costs) excluding medications.
- We are unable to offer this patient a grant.

As a physician who witness firsthand the frustration of couples facing infertility, I hope you will joint Amelia Molloy's Angels in helping the applicant. With the advance of technology, it is solely money which separates a couple from their dream of building a family.

Please feel free to contact me with any questions. Our website (www.ameliamolloysangels.com) has information on our process and more about who we are as a foundation.

Thank you!

Sincerely,
Ashley Antongiovanni
Founder/ CEO, Amelia Molloy's Angels
P: (661)800-7096
E: info@ameliamolloysangels.com