NYS Infertility Demonstration Program Application

Please answer all questions and provide the requested documentation for yourself and your partner. You will receive additional information once your application has been reviewed.

Personal Information

Patient's Name:______________________________

Address:______________________________ Apartment Number:______________

City:______________ State:______________ Zip:______________

Home Phone:______________ Work Phone:______________ Cell Phone:______________

Email Address:______________________________

Date of Birth:______________________

Partner's Name (If Applicable):______________________________

Address:______________________________ Apartment Number:______________

City:______________ State:______________ Zip:______________

Home Phone:______________ Work Phone:______________ Cell Phone:______________

Email Address:______________________________

Date of Birth:______________________

Initial Qualifying Information

Are you between 21 & 44 years old? ☐Yes ☐No (If NO, you are not eligible for this grant.)

Date of birth:______________________________

If YES, please scan and submit one of the following forms of documentation with this form:

- Driver's license
- Birth certificate AND photo ID
- Passport

Are you a legal resident of NY State? ☐Yes ☐No (If NO, you are not eligible for this grant.)

If YES, please scan and submit one of the following forms of documentation with this form:

- Driver's license
- Most recent tax return
- Tax return
- Recent utility bill

Do you have commercial health insurance? ☐Yes ☐No (If NO, you are not eligible for this grant.)

If YES, please scan and include a copy of your health insurance card(s), front and back.

Do you have a prescription drug plan? ☐Yes ☐No

If YES, please scan and include a copy of your prescription drug card(s), front and back.

Initial Qualifying Information Continued

Are you covered by Medicare or Medicaid Family Health Plans? ☐ Yes ☐ No (If YES, you are not eligible.)

Have you participated in the NYS Grant Program at any other program prior to this application? ☐ Yes ☐ No

If YES, how many IVF grant cycles?______________________________

What is your combined total income?______________________________

Please scan and include a copy of both patient's & partner's 1040 Federal income tax returns.

Is your combined total income less than $195,000? ☐ Yes ☐ No (If NO, you are not eligible.)

If any answers to the above questions resulted in an ineligible outcome, please do not proceed with this application.

If you are eligible, please answer all of the following questions.

Infertility

I am < 30 years old and have not conceived after 1 year of unprotected intercourse. ☐ Yes ☐ No ☐ N/A

I am age 30 or older and have not conceived after 6 months of unprotected intercourse. ☐ Yes ☐ No ☐ N/A

Medical

Have you been diagnosed with tubal disease? ☐ Yes ☐ No

If YES, provide a copy of the HSG report or surgical report showing the obstruction or diagnosis of tubal disease.

Have you had an elective tubal ligation? ☐ Yes ☐ No

Have you been diagnosed with enodmetriosis? ☐ Yes ☐ No

Do you have pelvic pain? ☐ Yes ☐ No

Have you been diagnosed with pelvic inflammatory disease? ☐ Yes ☐ No

Do you have irregular periods? ☐ Yes ☐ No

Do you have a history of in-utero DES exposure? ☐ Yes ☐ No

Have you received a diagnosis of unexplained infertility? ☐ Yes ☐ No

Do you have a medical condition that would contra-indicate a pregnancy? ☐ Yes ☐ No

Do you need or plan to undergo Preimplantation Diagnosis? ☐ Yes ☐ No

Do you need or plan to undergo Preimplantation Screening? ☐ Yes ☐ No

Height and Weight

Height:______________________ Weight:______________________

Male Factors

Does your infertility stem from male factors? ☐Yes ☐No ☐N/A

If YES, please provide documentation of your partner's most recent semen analysis.

Has your partner had a vasectomy? ☐Yes ☐No ☐N/A

Do you need donor sperm? ☐Yes ☐No

Past IUI/IVF Cycles

Have you had 4 or more cycles of Ovulation Induction with or without IUI? ☐Yes ☐No

If YES, how many IUI cycles?____________________

Have you had previous IVF Cycles that resulted in a live birth? ☐Yes ☐No

If YES, how many IVF cycles?____________________

Have you had IVF Cycles that were unsuccessful (no pregnancy or live birth)? ☐Yes ☐No

If YES, how many IVF cycles?____________________

Have you had IVF that were canceled (no retrieval or transfer)? ☐Yes ☐No

If YES, how many IVF cycles?____________________

Prior Screening

Last "Day Three" Levels (day 3 of your period)

FSH Level:____________________ Date:________________________

Estriadol Level:________________ Date:________________________

Last AMH Value:________________ Date:________________________

Your Doctors

Are you currently a patient of Long Island IVF? ☐Yes ☐No

If YES, who is your doctor?____

Ob/Gyn name:____

Ob/Gyn Address:______________________________ Ob/Gyn Office Phone:__________________________

Infertility providers previously consulted:

MD Name:____

Address:______________________________ Office phone:__________________________

Dates:____________________

MD Name:____

Address:______________________________ Office phone:__________________________

Dates:____________________

Primary Health Insurance Information

Plan Name:______________________________ ID Number:__________________________

Address:______________________________ Phone:__________________________

Please scan and include a copy of your health insurance card, front and back.

Primary Health Insurance Information Continued

Is this a private plan?	☐Yes	☐No	
Medicaid / Medicare / Family Health Plus?	☐Yes	☐No	
Is this Plan an HMO?	☐Yes	☐No	
Coverage provided for IVF?	☐Yes	☐No	☐Unknown

Secondary Health Insurance Information

Plan Name:____________________ ID Number:____________________

Address:____________________ Phone:____________________

Please scan and include a copy of your health insurance card, front and back.

Is this a private plan?	☐Yes	☐No	
Medicaid / Medicare / Family Health Plus?	☐Yes	☐No	
Is this Plan an HMO?	☐Yes	☐No	
Coverage provided for IVF?	☐Yes	☐No	☐Unknown

I / We understand that an application does not guarantee participation as funding or timing issues may prevent participation. Your participation in the grant can only be guaranteed after you have been approved and paid your cost share. All funds will be distributed on a first come, first served basis. By signing below, we certify that all information as provided on this form is true and correct.

Patient's Name____________________
Patient's Signature ____________________
Date____________________

Partner's Name____________________
Partner's Signature ____________________
Date____________________

If you have any comments or concerns, please feel free to share them with us:

Please email your completed application and all supplemental materials to **vitaliya@longislandivf.com** OR you may print and mail it to:

Long Island IVF
8 Corporate Center Drive, Suite 101
Melville, NY 11747