

**NYS Demonstration Infertility Project Application 5/2010**

Return to: NYU Fertility Center 660 First Avenue 5th floor  
New York, NY 10016 Attention: Grant Coordinator

Female Patient Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Tel # \_\_\_\_\_ Work Tel # \_\_\_\_\_

Are you a Legal Resident of NY State?  Yes  No *If no, you are not eligible*  
What is your 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:**

**-Driver's license or passport to verify Date of Birth.**

-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/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)**  Yes  No  
-Have you been diagnosed as infertile?  Yes  No

Please provide your MD's information Name \_\_\_\_\_  
Address \_\_\_\_\_  
Tel # \_\_\_\_\_

*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*

What was your last FSH level? \_\_\_\_\_ Date \_\_\_\_\_  
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 at NYU?  Yes  No  
Have you had IVF that was unsuccessful- i.e. no pregnancy or no live birth?  Yes  No How many \_\_\_\_\_  
Have you had IVF that resulted in a live birth?  Yes  No How many \_\_\_\_\_  
Have you had IVF cycles that were cancelled (did not go to retrieval or to transfer)  Yes  No How many \_\_\_\_\_  
Are you currently a patient at the NYU Fertility Center?  Yes  No Dr. \_\_\_\_\_  
What is your **total household income for 2009?** \$ \_\_\_\_\_

**You must provide a copy of your signed NYS and Federal Tax return for 2009. 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 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 to NYU for these services and that all treatments must be concluded prior to funding being exhausted or prior to the expiration of the contract. The current funding period expires 3/31/2011. By signing below we certify that all information as provided on this form is correct and true.**

Signature (Female Patient) \_\_\_\_\_ Date \_\_\_\_\_ Signature (Partner) \_\_\_\_\_ Date \_\_\_\_\_