NYS Demonstration Infertility Project Application

Return to: Northwell Health Fertility
300 Community Drive, Manhasset, NY 11030
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 or 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? _____
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 Northwell Health Fertility? Yes No Dr._____
What is your **total household income for 2016/2017? $_____**

You must provide a copy of your signed NYS and Federal Tax returns for 2016/2017. 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 Northwell Health Fertility. 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 directly to Northwell Health Fertility for applicable services. All treatments must be concluded prior to funding being exhausted and/or prior to the expiration of the contract on _____. My cycle may be cancelled if either of these items occurs. An application does not guarantee participation as funding or timing issues may prevent participation. By signing below we certify that all information as provided on this form is correct and true.

_____

Signature (Female Patient) Date Signature (Partner) Date