



LONG ISLAND IVF

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 endometriosis? 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: _____
- Estradiol 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@rmaliivf.com OR you may print and mail it to:

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

