



## Gift of Hope 2026

Applications must be received on or before June 30, 2026. The GIFT of HOPE grant will be awarded by August 15, 2026. Winner must begin treatment within 12 months from the date of the award.

### Donors:

- Dr. John Storment and Dr. Neil Chappell of Fertility Answers
- IVF lab partner Ovation Fertility
- Luminary Genetics
- YPS Anesthesia (Lafayette)
- Louisiana Anesthesiology (Baton Rouge)
- Various pharmaceutical partners

### Donated Services:

- Laboratory work considered part of a standard IVF treatment cycle (Ovation Fertility)
- Ultrasound exams considered part of a standard IVF treatment cycle
- Fertility medications prescribed for a standard IVF treatment cycle **up to \$3,000**
- One egg retrieval procedure
- One embryo transfer procedure
- Initial cryopreservation of unused embryos
- Anesthesia for IVF retrieval
- Preimplantation Genetic Testing for Aneuploidy (PGT-A) of embryos (Ovation Fertility) for **up to 8 embryos**

### Services Not Covered by the Gift of Hope:

- Off-site, long-term storage of cryopreserved eggs or embryos
- Medical complications arising from the IVF treatment
- Other or specialized laboratory testing expenses, as necessary or requested
- Other medical or surgical procedures not considered part of a standard IVF cycle (e.g., surgical sperm extraction, donor sperm, donor egg)
- Travel expenses
- Pre-screening laboratory fees
- **Additional medications required above the \$3,000 cap per couple**
- Donor egg or donor sperm fees
- Gestational carrier fees
- Any other fees and costs not covered by donation
- Pre-pregnancy genetic testing
- Preimplantation Genetic Testing of embryos for monogenetic disease PGT-M
- Other specialized PGT testing
- PGT-A testing for more than 8 embryos

### The Gift of Hope is Open to Any Applicant Who:

- Has a documented medical need for *in vitro* fertilization. A letter explaining this need is required, on letterhead, from a reproductive endocrinologist or gynecologic professional;
- Has a combined adjusted gross income of \$120,000 a year or less (financial documentation is required);
- Is a resident of Louisiana;
- Can describe in their own words the compelling nature of their need for fertility treatment;
- Has no or limited medical insurance coverage for infertility and IVF;

- Has medical insurance coverage for prenatal care;
- Agrees to appear in stories or other media about this program.

**Application Instructions for the GIFT of HOPE**  
**Please read these instructions carefully**

- Please complete all sections of the application. Incomplete applications will not be processed.
- Please choose a clinic location (Lafayette or Baton Rouge) that you would want the treatment performed at, should you be chosen for the grant. If a clinic is not chosen on the application, the selection committee will choose one for you, taking into consideration your residential location and if you have previously received treatment at either clinic.
- If you and/or your partner are self-employed, please include a letter describing your business, incorporation status and other details pertinent to your financial status.
- If you are not a current patient (within the last year) of Fertility Answers, you **MUST** have a letter summarizing your need for *in vitro* fertilization from your reproductive endocrinologist or gynecologic professional. Please have your physician include any pertinent labs and medical records so that your need for *in vitro* fertilization can be more fully assessed. Without this information, the committee cannot fully evaluate your need for *in vitro* fertilization or your chances of success with this treatment.
- Application and all required documents must be received on or before **Monday, June 30, 2026**. Please hand deliver or mail documents to:

**Fertility Answers**  
**206 E. Farrel Road**  
**Lafayette, LA 70508**  
**Attn: GIFT of HOPE**

- After we receive and process your completed application you will be notified by email. Please include a current email address with your application.
- If you have questions about the program or your eligibility, please email your questions to: **giftofhope@fertilityanswers.com**.
- Donation will be awarded by August 15, 2026, and recipient will be contacted by telephone.
- Selected applicant will be required to sign standard medical Informed Consent and Acknowledgement of Risk forms along with consents from each donating entity before *in vitro* fertilization cycle commences.
- Selected applicant may be declined the award if they fail to meet prescreening needs for *in vitro* fertilization. In this case, another couple may be selected to receive the GIFT of HOPE.

# Gift of Hope

## Application Checklist

To be considered for the GIFT of HOPE award, all applicants must provide the following information. Incomplete applications will not be considered.

- ✓ A fully completed and signed application form.
- ✓ If you are NOT a patient of Fertility Answers (within the last two years), you will need to provide a signed letter of referral (on letterhead) from your gynecological professional providing a diagnosis and medical need for IVF treatment, plus copies of any pertinent medical records or lab results.
- ✓ Proof of income/wages. Please provide a copy of IRS form 1040 - US Individual Income Tax Return of your 2025 Federal Income tax return (both returns if partners file separately). Please do not send original documents. Failure to provide sufficient income documentation will disqualify your application.
- ✓ Copy of medical insurance cards (front and back) for both applicant and partner.
- ✓ A personal letter, statement or other documentation to the committee explaining the compelling nature of the applicant's circumstances, struggles with infertility and why you feel you are a candidate for the award. Any video submissions must be less than 5 minutes in length.
- ✓ A signed media release giving the Gift of Hope full rights to tell the applicant's story.
- ✓ Application must be received on or before **Monday, June 30, 2026**. **Any application received past this date will not be considered.**
- ✓ If you require any materials to be returned, please indicate this when sending in your application as all applications and accompanying materials are destroyed after award selection. Original application and accompanying materials that you desire returned to you can be picked up from our Lafayette office after August 15, 2026.

# Gift of Hope

## Frequently Asked Questions

### **What is the Gift of Hope?**

The Gift of Hope awards grants for a free IVF treatment cycle to Louisiana couples each year.

### **Must both partners be Louisiana residents?**

Yes, both applicants must be Louisiana residents.

### **How often is the Gift of Hope awarded?**

At present, grants are awarded annually in the spring of each year.

### **How many grants are awarded?**

One or two grants are awarded each year. Please check our website for more information.

### **Does the grant apply to intrauterine insemination (IUI) and other procedures?**

The Gift of Hope applies only to a single, standard in vitro fertilization treatment (IVF) cycle. However, the selection committee may award additional grants to other couples exclusively for intrauterine insemination (IUI) if funding allows.

### **At which Fertility Answers clinic will the IVF procedure be performed?**

The IVF procedure will be conducted at Fertility Answers in Lafayette, LA, or at Fertility Answers in Baton Rouge, LA.

### **How do I know which clinic to select for the treatment?**

Please indicate on your application form which location (Baton Rouge or Lafayette) that you are applying for the Gift of Hope. Location preference should be chosen based on your residence or, if you are a patient of Fertility Answers, the clinic you go to for treatment. If you do not select a location, the selection committee will select one for you.

### **What IVF costs are actually covered by the Gift of Hope?**

The Gift of Hope Grant covers the following procedures:

- Laboratory work indicated for a standard IVF treatment cycle
- Ultrasound exams indicated for a standard IVF treatment cycle
- Medications prescribed for a standard IVF treatment cycle (**cap of \$3,000 per cycle**)
- One Retrieval of eggs
- One Transfer of embryos
- Initial cryopreservation of unused embryos, if applicable
- Anesthesia during egg retrieval
- Preimplantation Genetic Testing for Aneuploidy, PGT-A, of embryos (limited to 8 embryos)

### **What IVF costs are NOT covered by the Gift of Hope award?**

Winning applicants of the Gift of Hope may be required to pay these expenses related to their in vitro fertilization cycle:

- Off-site, long-term storage of cryopreserved eggs or embryos
- Medical complications arising from the IVF treatment
- Other or specialized laboratory testing expenses, as necessary or requested
- Other or specialized medical procedures or surgery, as necessary or requested
- Donor egg or donor sperm expenses
- Medication required above the \$3,000 cap
- Travel expenses
- Pre-screening laboratory fees
- Certain fertility medications
- Pre-pregnancy genetic testing
- Pre-implantation Genetic Testing for Monogenetic Disease (PGT-M)
- Other specialized PGT testing
- PGT-A embryos testing for more than 8 embryos
- Other fees and costs not covered by donation

### **I already have frozen embryos from a past IVF cycle. Will the Gift of Hope cover a Frozen Embryo Transfer (FET) cycle?**

No. The Gift of Hope is only for a new IVF cycle.

### **Can the time for using the grant be extended beyond one year?**

No. The couple receiving the Gift of Hope award must commence (start) their IVF cycle within 12 months of the award.

### **Can I apply the grant money to treatment I have already received?**

No, the grant is for a new cycle and cannot be used for a cycle or treatment that is either already in progress or has been completed.

**Is there an age limit?**

No, there is no age limit to apply for the Gift of Hope.

**Can you have children already?**

Yes, but the selection process is preferential to those without children.

**Is there an annual minimum or maximum income?**

There is no minimum income limit, however, the selection process is preferential to couples earning enough to support a child. The maximum income limit allowed to apply is \$120,000 Adjusted Gross Revenue. This amount can be found on your federal tax return.

**What medical insurance coverage is required?**

Couples applying must be able to provide proof of medical insurance to cover their health care needs including the cost of prenatal and maternity care. Please check your policy to make sure you also have prenatal and maternity coverage.

**What if my insurance also covers infertility services and IVF?**

You may still apply, however, the selection process is preferential to those applying whose insurance does not cover or has limited coverage of infertility or IVF.

**Do I need to provide a physician's written recommendation?**

If you are NOT already a patient at Fertility Answers (seen within the last 12 months), you will need to provide a written recommendation from your physician, on letterhead, of your need for IVF to conceive. We also encourage you to ask your referring physician to provide as much documentation as possible, including lab values, with your application as this helps our selection committee determine your need and possible success with IVF. The date on the documents should be within the past year.

**What lab information would be helpful to add to our application?**

Specific lab information that would be helpful in determining your candidacy for the Gift of Hope includes FSH levels (follicle stimulating hormone) and AMH levels (anti-Mullerian hormone). These values should be within the past 6 months to a year.

# Gift of Hope 2026 APPLICATION FORM

Please print and fill out **all** sections. Incomplete applications will not be processed.

APPLICANT INFORMATION			
Applicant Name (First, Middle/Maiden, Last)	Applicant Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other	Any children? <input type="checkbox"/> Y <input type="checkbox"/> N Ages: Stepchildren? <input type="checkbox"/> Y <input type="checkbox"/> N	
Applicant Occupation	Applicant Employer Name & Address  Employer Phone #	Applicant Birthdate /     / Age:	
Home Street Address		City	State
Applicant Email address		Cell #	Zip
Partner Name (First, Middle, Last)		Partner Birthdate /     / Age:	
Partner Occupation	Partner Employer Name & Address  Employer Phone #	Any children? <input type="checkbox"/> Y <input type="checkbox"/> N Ages: Stepchildren? <input type="checkbox"/> Y <input type="checkbox"/> N	
<b>CHOOSE YOUR PREFERRED CLINIC:</b> <input type="checkbox"/> Lafayette <input type="checkbox"/> Baton Rouge			
INFERTILITY MEDICAL HISTORY			
Current Gynecologist/Fertility Specialist Name & Address			Phone Number
Have you ever been pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No        If yes, how many times? _____ How many live births? _____ Losses? _____			
Have you ever had an IVF procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No        If yes, how many? _____			
With which physicians or clinics: _____			
Do you have any frozen embryos? <input type="checkbox"/> Yes <input type="checkbox"/> No        If yes, how many and where are they stored? _____			
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No        If yes, how much? _____ Height _____ Weight _____			
Any other medical problems? _____			
If applicant over 35 years of age, results of most recent FSH test: _____ AMH test: _____			
Brief Fertility Summary (Diagnosis): _____			
APPLICANT SIGNATURES			
I/we the undersigned declare my/our application to be the full truth to the best of our knowledge. I/we have read through the application instructions and understand what is covered and not covered by the Gift of Hope IVF Grant, and what services I/we may still need to pay for.			
X _____ Applicant Signature		_____ Date	
X _____ Partner Signature		_____ Date	
FOR OFFICE USE ONLY			
Date received _____		Insurance: _____	

### **Applicant Consent**

I/We declare my/our application to be the full truth to the best of my/our knowledge. I/we have read through the application instructions, eligibility requirements and frequently asked questions. I/we understand that selected applicant will be required to sign additional Medical Consent forms before infertility treatment cycle commences. I/we understand that I/we may be declined the award if I/we fail to meet prescreening needs for in vitro fertilization. In this case, another couple may be selected to receive the GIFT of HOPE.

### **Acknowledgement of Gift of Hope Award Limits**

I/we have read through the application instructions, eligibility requirements and frequently asked questions found on the Fertility Answers website and understand what is covered and not covered by the Gift of Hope IVF Grant. I/we understand there are some services outside the scope of the Gift of Hope IVF cycle that I/we may still need to pay for. This includes a \$3,000 cap on medications required for the IVF cycle. I/we understand the financial responsibility for any additional services and for medication costs over \$3,000.

### **Embryo Genetic Testing Acknowledgement**

I/we understand that embryo genetic testing (Preimplantation Genetic Testing-A) for the Gift of Hope IVF cycle is limited to eight (8) embryos. If additional embryos require testing beyond this limit, I/we understand that I/we are financially responsible for the cost of this testing.

## **Copyright and Media Release**

### **Rights Granted to GIFT of HOPE**

The undersigned, an applicant to participate in GIFT of HOPE, an IVF grant program sponsored by Fertility Answers LLC, grants and conveys to GIFT of HOPE the exclusive rights to develop and tell the applicant's Story related to the applicant's efforts to build a family, including but not limited to, information regarding the applicant and partner, the applicant's immediate family members, the applicant's medical and financial struggles related to pregnancy, pregnancy loss, infertility, fertility treatment, etc. (known in this agreement and release collectively as your "Story"). Applicant grants GIFT of HOPE the exclusive right to share your Story in any and all media, now and hereafter developed, including but not limited to print media including books and magazines, and electronic media including all donors' websites and social media platforms.

Applicant agrees to be truthful with respect to all information provided to GIFT of HOPE for inclusion in applicant's Story. Applicant understands that providing incomplete, inaccurate or false information will cause significant harm to GIFT of HOPE and agrees to indemnify and hold GIFT of HOPE and its respective donor organizations harmless against any claim, demand, or recovery brought against GIFT of HOPE as publisher of the applicant's Story with respect to any information applicant provides that is not complete, correct, accurate and truthful. Upon selection for participation in GIFT of HOPE, applicant agrees to provide GIFT of HOPE and/or its agents with photographs of applicant, applicant's partner and immediate family members and additional information to facilitate the telling of applicant's Story as requested by GIFT of HOPE. Applicant agrees to allow GIFT of HOPE and/or its representatives or agents to attend, photograph, videotape and otherwise record for purposes of telling applicant's Story, applicant's medical appointments and other events related to applicant's efforts to build a family. Applicant agrees and understands that

she/he shall receive only the donated medical services included in the program as consideration for granting these rights to GIFT of HOPE and its respective donor organizations and shall receive no other consideration or compensation for granting these rights. Applicant hereby waives claim to any royalties, fees or other compensation GIFT of HOPE may receive related to publishing or other telling of applicant's Story.

THE UNDERSIGNED APPLICANT AND PARTNER HAVE READ AND UNDERSTAND THE RIGHTS GRANTED TO GIFT OF HOPE AND ITS RESPECTIVE DONOR ORGANIZATIONS IN THIS COPYRIGHT AND MEDIA RELEASE AND VOLUNTARILY GRANT THE RIGHTS DETAILED IN THIS RELEASE TO GIFT OF HOPE IN CONSIDERATION FOR THE OPPORTUNITY TO APPLY TO PARTICIPATE IN THE GIFT OF HOPE PROGRAM.

\_\_\_\_\_  
Applicant signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's partner signature

\_\_\_\_\_  
Date