HelpCureHD

GRANT APPLICATION

PERSONAL INFORMATION-APPLICANT 1

Full Name :

Date of birth : ____ / ____ / ____ **Gender :** ☐ Male ☐ Female ☐ Other

Address :

Phone Number : **E-Mail** :

Have you lived at this address for at least 2 years? If not, previous address? :

Status : ☐ Single ☐ Married ☐ Divorced ☐ Other

Occupation : **Are you a US Citizen ? :** ☐ Yes ☐ No

Please attach 2 most recent 1099's or W-9's

Employer Name :

Employer Phone :

Years on the job :

Have you ever been convicted of a crime? : ☐ Yes ☐ No **If yes? :**

HUNTINGTON'S DISEASE STATUS

☐ **History of HD in the family, but I don't want to know my status.**

☐ **History of HD in the family; I am willing to be tested.**

☐ **I have been tested for the HD gene. HD results attached.**

☐ **Applying along with my significant other who is affected.**

MEDICAL HISTORY

If Female

Height/Weight :

If female, age of first period :

History of endometriosis? :

History of pelvic infection? :

Surgical History :

If Male

Have you ever seen a urologist? :

If yes, please explain :

Doctor's name :

Checklist:

*Copy of driver's license
*Copy of Insurance card (front & back)
*Last 2 years of W2s or 1099s
*Background Check
*Proof HD for affected applicant. Medical records or death certificate.
*Medical Release Waiver

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GRANT APPLICATION

PERSONAL INFORMATION-APPLICANT 2

Full Name :

Date of birth : ____ / ____ / ____ **Gender :** ☐ Male ☐ Female ☐ Other

Address :

Phone Number : **E-Mail** :

Have you lived at this address for at least 2 years? If not, previous address? :

Status : ☐ Single ☐ Married ☐ Divorced ☐ Other

Occupation : **Are you a US Citizen ? :** ☐ Yes ☐ No

Please attach 2 most recent 1099's or W-9's

Employer Name :

Employer Phone :

Years on the job :

Have you ever been convicted of a crime? : ☐ Yes ☐ No **If yes? :**

HUNTINGTON'S DISEASE STATUS

☐ **History of HD in the family, but I don't want to know my status.**

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HISTORY TOGETHER

Are you and the applicant married? : ☐ Yes ☐ No

If yes, when did you get married? : _____

Have you been trying to conceive? : ☐ Yes ☐ No

If yes, how long have you been trying to conceive? : _____

Diagnosed with infertility? : ☐ Yes ☐ No

If yes, please explain : _____

Do you have children together? : ☐ Yes ☐ No

If yes, how many? What is their HD status? : _____

Does your insurance cover fertility? : ☐ Yes ☐ No

If yes, please explain : _____

Have you had any prior IVF or genetic testing? : ☐ Yes ☐ No

If yes, what was the outcome? _____

HOW DID YOU HEAR ABOUT HELPCUREHD?

- ☐ **Friend/Family Member**
- ☐ **TV/Social Media**
- ☐ **Internet/Website**
- ☐ **Physician/Clinic**

Name : _____

AUTHORIZATION

By signing below, I authorize Horizon Community Foundation and HelpCureHD, along with its PGT Selection Committee, to obtain written, oral, or other information from my physicians, law enforcement agencies, consumer reporting agencies, or other individuals who may have knowledge relevant to my character, general reputation, personal characteristics, living, criminal background, or driving record. Horizon Community Foundation and HelpCureHD reserve the right to conduct this investigation at any time. I acknowledge that all information collected will be shared with the HelpCureHD Selection Committee.

In addition, I/we hereby grant Horizon Community Foundation and HelpCureHD permission to use my/our image, likeness, and voice in any live or recorded transmission, reproduction, or photography, in any and all media now known or hereafter developed. I/we understand that the selection of grant recipients is solely at the discretion of Horizon Community Foundation and HelpCureHD. I/we further agree not to seek compensation of any kind with respect to the decision-making process, selection criteria, or outcome of the grant awards.

Applicant 1 (print) : _____

Applicant 1 (sign) : _____

Date : _____

Applicant 2 (print) : _____

Applicant 2 (sign) : _____

Date : _____

Checklist:

*Copy of driver's license
*Copy of Insurance card (front & back)
*Last 2 years of W2s or 1099s
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MEDICAL INFORMATION RELEASE, WAIVER OF LIABILITY & INDEMNIFICATION

I, the undersigned, give permission to HelpCureHD Foundation, Horizon Community Foundation, its selection committee, and their designated partners and representatives to review the medical information I have provided in connection with my application for financial assistance through the PGT-IVF Grant Program. By signing below, I authorize the committee to share this information internally as necessary to accurately review my application.

I further agree to 1) waive, release, and discharge Horizon Community Foundation and the HelpCureHD Foundation, its officers, agents, employees, partners, affiliates, and volunteers from any and all liability, damages, claims, demands, or causes of action of any kind, including personal injury, property damage, theft, or loss, arising from my/our participation in the PGT-IVF Grant Program; 2) Indemnify and hold harmless Horizon Community Foundation and the HelpCureHD Foundation, its officers, agents, employees, affiliates, and volunteers against all liabilities or claims made by third parties arising out of my/our participation in the program; and c) Assume full responsibility for the risks involved, including but not limited to bodily injury, disability, death, or property damage, whether caused by negligence or otherwise.

□ I understand that I may refuse to sign this authorization, but that refusal will disqualify me and my co-applicant from any grant consideration.

□ I acknowledge that all medical records submitted may be reviewed by multiple parties solely for the purpose of evaluating the HelpCureHD PGT-IVF Grant application.

□ I authorize the use and disclosure of my protected health information as described above.

Applicant 1 (print) :		**Applicant 2 (print)** :	
Applicant 1 (sign) :		**Applicant 2 (sign)** :	
Date :		**Date** :	

Checklist:

*Copy of driver's license
*Copy of Insurance card (front & back)
*Last 2 years of W2s or 1099s
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