ANEDEN GIVES GRANT PROCESS
REQUIREMENTS & TIMELINES

The ANEDEN Gives Grant Process Requirements and Timelines for each applicant are outlined below:

1. To initiate the grant application process, each applicant must submit an online application via the ANEDEN Gives *Grant Process* webpage.

2. All communications will be via email to the email address you have provided in your submitted online application. Note that all applicants in the submission will receive all correspondences.

3. If your submitted online application meets the *Grant Eligibility Criteria* (displayed on the same webpage above), you will receive an email to electronically sign the attached Medical Release Authorization. This email from DocuSign will **expire** within **7 days** from the date sent.

4. After the Grant Application Window has closed, the ANEDEN Gives Board of Directors will review and PRE-SELECT the grant awardees. See the *Grant Process* webpage for the review dates.

5. If you are PRE-SELECTED for a grant award, you will receive an email with a request for your most recent tax return. An example of that form can be found here https://www.irs.gov/pub/irs-pdf/f1040.pdf

6. You must submit the tax returns for ALL members of your family and/or those included in the submitted online application by the **deadline** provided in the email request from the ANEDEN Gives Team. If you do not submit your most recent IRS Form 1040 by the deadline, your pre-selection will be cancelled.

7. If you are PRE-SELECTED, you will receive a request to authorize a background check from ***IntelliCorp.net*** if your tax return matches the information provided in your online application and meets the *Grant Eligibility Criteria*. A background check will be completed for ALL applicants in your online application.

8. If the results of your background check do not show any adverse results, your grant award will be finalized and a grant award letter will be issued and sent via email.

9. The grant award letter will provide details on the specifics of your grant – grant amount, deadline for using the grant funds and who receives the grant funds.

If you have any questions about this process, please email us at apply@anedengives.com.

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION
(To be completed by Patient)

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my health care provider, the **[CLINIC NAME]** to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: ANEDEN GIVES

Purpose: I authorize the release of my health information for the following specific purpose: **ANEDEN GIVES GRANT PROCESS**.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, any treatment received by me and the outcome of all treatments received by me.

Term: I understand that this Authorization will remain in effect after my treatment at the Houston Fertility Institute and up to 6 months after childbirth if applicable.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

NOTE: *This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.*

____________________________________ _________________

Signature – Patient **Date**

____

Legal Name – Patient

PATIENT VERIFICATION (To be completed by Clinic)

Patient Name ____

Patient Date of Birth ___________________________ (MM/DD/YYYY)

Patient Currently Undergoing Treatment at the **[CLINIC NAME]** **(Clinic)?**
____YES _____NO

THIS FORM HAS BEEN COMPLETED BY CLINIC REPRESENTATIVE:

REPRESENTATIVE'S NAME ____

CLINIC NAME ____

CLINIC ADDRESS

Street Address ____

City _____________________ State__________________ Zip Code _________________

PHONE ______________________________________

EMAIL _______________________________________

The above patient verification information is accurate to the best of my knowledge

____ __________________
SIGNATURE - **DATE**

INSTRUCTIONS
Page 1 to be completed by applicant, Page 2 to be completed by Clinic. Complete and Signed Copies of both pages will be emailed to applicants, clinic and ANEDEN Gives.