THE SAMANTHA & KYLE BUSCH BUNDLE OF JOY FUND GRANT APPLICATION

Tax ID 20-5950643

Revised January, 2023

APPLICATION INSTRUCTIONS

Thank you for applying for a financial assistance grant through The Samantha and Kyle Busch Bundle of Joy Fund (Bundle of Joy Fund).

The Bundle of Joy Fund was founded in 2015 after Kyle and Samantha Busch experienced their own struggles with infertility and ultimately went through IVF at the REACH fertility clinic to have their son Brexton. After realizing the high cost of treatment and medications, Kyle & Samantha were devastated to know that finances could prevent a loving, deserving couple from starting a family that they so desperately longed for. They felt they were put through their own struggles and called to pay it forward by helping other couples to have their own bundle of joy.

The Bundle of Joy Fund is dedicated to advocating for infertility education and awareness and removing financial barriers by granting monetary awards to couples who require fertility treatments to have their own bundle of joy. Since launching in 2015, the fund has distributed over $1.3 Million in grants to more than 100 couples resulting in more than 65 babies (and growing).

Bundle of Joy Fund grants are need-based financial assistance for infertile couples struggling to pay the high cost of IVF treatment. Applicants must be current patients at REACH with a diagnosis of infertility (who have not yet started treatment of items for which they seek funding) and be legal permanent U.S. residents in North or South Carolina, age 18 or older.

The grants are distributed throughout the year. The number of grants awarded as well as the amount of funding may change depending on the fertility needs of the applicant and the funds raised by The Bundle of Joy Fund that year. Please know that we cannot fund all those who apply as much as we wish we could.

Applications may be obtained and submitted through REACH after an initial consultation. **The deadline for applications for the final round of 2021 is November 1, 2021. Deadlines for 2022 are as follows:**

1. Round 1: Application deadline on March 1, 2023. Grant reveals starting on or around April 15, 2023.*
2. Round 2: Application deadline on July 3, 2023. Grant reveals starting on or around August 15, 2023.*
3. Round 3: Application deadline on November 1, 2023. Grant reveals starting on or around December 15, 2023.*

**Must provide contact information within this application for a surprise grant reveal. Please see CONSENT portion of this application.*

Additionally, please review the following guidelines:

- The application must be filled out completely and truthfully to be considered. Applications missing information or attachments will not be reviewed and considered withdrawn. Please see the checklist attached and see your nurse/doctor or the financial office at REACH for help completing any portion of the application.
- Grant funding will be based on the dollar amount of the treatment(s) needed with input from the staff at REACH. The maximum grant amount is $20,000 per couple.
- Donation money can only be used for services not yet received from REACH. Funds cannot be used toward treatments that have already begun. Funds are dispensed directly to REACH and not to the couple applying for the fund.
- Grant funding can only be used for the following treatments/services related to infertility treatment at REACH: single cycle IVF, donor cycle, embryo adoption, frozen transfer, genetic testing, medication, anesthesiology, embryo storage for up to one year and/or gestational carrier fees. Note that grant funding does not cover IUIs or other related infertility-related treatments nor can it be used for multi-cycle Attain packages.
- All applicants are required to apply for the Compassionate Care Program through EMD Serono, which provides eligible patients with savings on medications based on income. Eligible patients may save 25%, 50%, or 75% off the self-pay price of EMD Serono's fertility medications. The savings allows us to help reduce the overall cost of treatment and help more couples. Applicants who do not receive Bundle of Joy Fund grants are still able to benefit from the Compassionate Care Program savings.
- Support is considered only for couples or individuals who are legal permanent U.S. residents, residing in North or South Carolina, with documented infertility through the REACH.
- If a fund recipient does not use the full amount of funds provided, the ancillary funds will be returned to The Samantha and Kyle Busch Bundle of Joy Fund for future disbursements to additional couples in need.
- Funds received must be used within 12 months of the date of distribution unless approved by The Bundle of Joy Fund. Any funds not used will be returned to The Samantha and Kyle Busch Bundle of Joy Fund for future disbursements to additional couples in need.
- Grant recipients are asked to stay connected and participate in fundraising activities for the Bundle of Joy Fund to allow us to grow and continue to provide support to families to have their own bundle of joy.
- Any changes in fertility, family status or contact information that occur following the submission of an application should be reported to REACH immediately. Failure to do so may result in forfeiture of the donation money.
- If you submit an application and do not receive a grant, you may submit a new application for the next round. Applications are not saved and must be resubmitted for each round.
- Completed applications should be submitted through REACH for initial review.

All applications submitted are reviewed for accuracy by REACH. Once those applications have been verified, The Samantha and Kyle Busch Bundle of Joy Fund will be responsible for the final review of all applications and will make the decision as to who will receive funding. All complete applications are reviewed and considered regardless of race, religion, ethnicity or national origin, age, or sexual orientation.

All information provided in this application is considered confidential and will not be shared with any agency or person outside of REACH, The Samantha and Kyle Busch Bundle of Joy Fund Board of Trustees and agents of The Samantha and Kyle Busch Bundle of Joy Fund.

If you have questions about the application process, please see your nurse/doctor or the financial office at REACH or contact the Managing Director at jessica.turner@bundleofjoyfund.org.

The Samantha and Kyle Busch bundle of joy FUND

APPLICATION CHECKLIST

- ☐ I am a **current patient** at REACH with diagnosis of infertility requiring IVF treatment.
- ☐ I **have not yet paid** for services for which funding is being requested.
- ☐ I am a legal permanent **U.S. citizen**, age 18 or older, **residing in North or South Carolina**.
- ☐ Allow yourself ample time to complete all steps of the application process and submit by the stated deadline.
- ☐ **Review entire application** before starting to ensure you have a complete understanding of questions being asked, particularly treatment costs and financial background.
- ☐ Meet with the REACH financial office and obtain an **official Patient Estimate** to complete your application.
- ☐ **Review your infertility insurance** benefits (if applicable) to complete your application.
- ☐ Gather pay stubs, W-2s or other tax-related documents and monthly bills to complete the Financial Information section.
- ☐ **Apply for the Compassionate Care Program** at www.fertilitysavings.com.
- ☐ **Complete entire grant application**.
- ☐ **Attach personal statements** (preferably typed).
- ☐ **Attach signed authorization** form (see below).
- ☐ **Attach copy of Patient Estimate** provided by the REACH financial office (see below).
- ☐ **Attach the Compassionate Care Program response** (typically received within 2-3 days of application via email).
- ☐ **Photos** of you, your spouse and/or family are welcome, but **please send copies** as originals will not be returned.

The Samantha and Kyle Busch bundle of joy FUND

APPLICATION COVER SHEET

Please type or clearly print (preferably in all caps).

Applicant #1 Full Name: _____

Date of Birth: _____ Age: _____

Please note the following question is optional and is only being asked due to private grants awarded from specialty groups.

What race(s) do you identify as? _____

Applicant #2 Full Name: _____

Date of Birth: _____ Age: _____

Please note the following question is optional and is only being asked due to private grants awarded from specialty groups.

What race(s) do you identify as? _____

What is the total projected cost of treatment? _____
(Reference the Patient Estimate provided by REACH Fertility Center financial office.)

How much funding are you requesting (cannot exceed $20,000)? _____
(Recommended to complete the Treatment Budget Proposal prior to answering.)

If selected, what amount can you contribute toward treatment? _____
(Include personal and friends/family contributions, GoFundMe, etc. Recommended to complete the Treatment Budget Proposal prior to answering.)

Have you previously applied for The Samantha and Kyle Busch Bundle of Joy Fund Grant? YES NO If yes, when? _____

APPLICANT #1 BACKGROUND

Please type or clearly print (preferably in all caps).

Legal Name: _____
Date of Birth: _____ Age: _____
Email Address: _____
Cell Phone: _____
Home Street Address: _____
City: _____ State: _____ Zip: _____

Current Employer: _____
Current Job Title: _____
Length of Employment: _____ Annual Salary (before taxes): _____

Are you married? YES NO If yes, how long? _____
Do you currently have any children? YES NO If yes, how many? _____
Are you an active or retired member of the military? YES NO
Do you use tobacco products? YES NO
Have you ever been arrested? YES NO *(If "yes", please attach explanation. Failure to do so will result in disqualification for grant consideration.)*

Have you ever been convicted of a felony or misdemeanor? YES NO *(If "yes", please attach explanation. Failure to do so will result in disqualification for grant consideration.)*

Do you have insurance/employer sponsored support that will assist with the cost of fertility treatment?
YES NO INCOMPLETE COVERAGE *(Please provide further detail in Health Insurance section.)*

Are you related to anyone affiliated with Kyle Busch Motorsports or The Samantha and Kyle Busch Bundle of Joy Fund? YES NO
If YES, please let us know who: _____

How did you hear about us? (please check all that apply)

- ☐ Friend/Family
- ☐ Clinic Referral from Clinic Name: _____
- ☐ Social Media
- ☐ Television/Radio
- ☐ Email Marketing
- ☐ Infertility Events
- ☐ Other: _____

APPLICANT #2 BACKGROUND

Please type or clearly print (preferably in all caps).

Legal Name: _____
Date of Birth: _____ Age: _____
Email Address: _____
Cell Phone: _____
Home Street Address: _____
City: _____ State: _____ Zip: _____

Current Employer: _____
Current Job Title: _____
Length of Employment: _____ Annual Salary (before taxes): _____

Are you married? YES NO If yes, how long? _____
Do you currently have any children? YES NO If yes, how many? _____
Are you an active or retired member of the military? YES NO
Do you use tobacco products? YES NO

Have you ever been arrested? YES NO *(If "yes", please attach an explanation. Failure to do so will result in disqualification for grant consideration.)*
Have you ever been convicted of a felony or misdemeanor? YES NO *(If "yes", please attach explanation. Failure to do so will result in disqualification for grant consideration)*

Do you have insurance/employer sponsored support that will assist with the cost of fertility treatment?
YES NO INCOMPLETE COVERAGE *(Please provide further detail in Health Insurance section.)*
Are you related to anyone affiliated with Kyle Busch Motorsports or The Samantha and Kyle Busch Bundle of Joy Fund? YES NO
If yes, please let us know who: _____

How did you hear about us? (please check all that apply)

- ☐ Friend/Family
- ☐ Clinic Referral from Clinic Name: _____
- ☐ Social Media
- ☐ Television/Radio
- ☐ Email Marketing
- ☐ Infertility Events
- ☐ Other: _____

FERTILITY HISTORY & BACKGROUND

Please type or clearly print (preferably in all caps).

Who is your doctor at the REACH Fertility Center? _____
How long have you been a patient at REACH Fertility Center? _____
What is the date of your last appointment at REACH Fertility Center? _____
What is your anticipated/target date to start treatment? _____
(Bundle of Joy Fund does not reimburse for procedures that have already begun.)

What is your infertility diagnosis? _____

What procedure(s) is needed?

- ☐ IVF
- ☐ IVF with genetic testing
- ☐ IVF with donor sperm, egg or embryo
- ☐ Other:

_____

How long have you been attempting to conceive? _____
Have you ever been pregnant? YES NO
If yes, when? _____

Has Applicant #1 or Applicant #2 done any previous infertility treatments/procedures at REACH Fertility Center or another clinic? YES NO
If yes, please list any procedures such as medications to stimulate, IUI, IVF, etc. including dates/results:
_____

_____

_____

_____

Have you received treatment at any other fertility clinic? YES NO
If yes, which clinic and when? _____
Are you doing genetic testing such as CCS, PGS, PGD? YES NO
If yes, which test(s)? _____
Are you using an egg donor? YES NO
Are you using an embryo donor? YES NO
Are you using a sperm donor? YES NO
Are you using a gestational carrier? YES NO

Please include any other relevant information regarding your history of infertility: _____

_____

_____

_____

HEALTH INSURANCE INFORMATION

Please type or clearly print (preferably in all caps).

Does Applicant #1 and/or Applicant #2 have insurance/employer sponsored support that will assist with the cost of infertility procedures (including medication, diagnosis and/or treatment)?

YES NO INCOMPLETE COVERAGE

If YES or INCOMPLETE COVERAGE, please describe your benefits, deductible, maximum out of pocket, what is covered and what is not covered:

_____

_____

_____

If your insurance covers any type of infertility treatment, what benefits have you received up to this point? Include specific dollar amount of benefits received:

_____

_____

_____

If your insurance covers any type of infertility treatment, what, if any benefits do you have remaining? Include specific dollar amount and benefits available:

_____

_____

_____

Does Applicant #1 and/or Applicant #2 have prenatal coverage?

YES NO INCOMPLETE COVERAGE

Does Applicant #1 and/or Applicant #2 have coverage for dependents?

YES NO INCOMPLETE COVERAGE

If you answered NO or INCOMPLETE COVERAGE to either question, please explain:

_____

_____

_____

_____

FINANCIAL INFORMATION

Please type or clearly print (preferably in all caps).

Total gross annual household income: _____

(Combined gross income, before taxes, plus other annual revenue from Applicant #1 and Applicant #2)

How much have you spent to date out-of-pocket on infertility? _____

(This is a total of all past expenses for procedures, treatments, medication, etc.)

Have you taken out any personal loans/used credit cards to pay for infertility treatment? YES NO

If yes, what amount? _____

If yes, are you currently paying on these accounts? YES NO

If yes, what is the balance due? _____ Monthly payment? _____

Have you received any other financial assistance to pay for IVF (including contributions from friends/family, fundraisers, GoFundMe pages, etc.? YES NO
If yes, what amount have you received? _____

Are you applying for/have you received any other financial assistance for fertility treatments (i.e. Livestrong Fertility, BabyQuest, Cade Foundation, etc.)? YES NO
If yes, please elaborate: _____

_____

Please detail all sources of monthly household income from Applicant #1 and Applicant #2 after taxes and withholdings:

Salary & wages (take-home after taxes/withholdings)	
Self-employment income	
Overtime, commission, tips, bonuses, etc.	
Dividends, interest	
Trusts, annuities	

Pension, retirement funds	
Social security income	
Disability, unemployment insurance or worker's comp	
Public assistance (welfare)	
Income producing property	
Other:	
Total monthly income (take-home after taxes/withholdings)	

Please detail monthly household expenses (or acknowledge "n/a") for Applicant #1 and Applicant #2.

Mortgage / Rent (circle one)	
HOA fees (monthly average)	
Utilities (electric, gas, water, trash, cable/internet, etc.)	
Car payment(s)	
Phone(s)	
Insurance (auto, homeowners/renters, etc.)	
Life Insurance / IRA (in addition to employer benefits)	
Groceries	
Household expenses/services	
Clothing	
Entertainment / Eating out	
Childcare / School	
Petcare	
Education loans	
Credit cards / Personal loans	
Alimony / Patrimony	
Child Support	
Fertility Treatment	

Other Medical Debts / Medication Expenses	
Fertility Savings	
General Savings	
Charitable / Religious Giving	
Other:	
Other:	
Other:	
Other:	
Total Monthly Household Expenses	

What is the current total balance of savings and checking accounts for Applicant #1 and Applicant #2?

Checking: _____ Savings: _____

What is the net worth of your retirement/IRA savings plans?

Applicant #1: _____ Applicant #2: _____

Present cash value for life insurance policies?

Applicant #1: _____ Applicant #2: _____

Present value of any money market accounts or CDs?

Applicant #1: _____ Applicant #2: _____

Are you or have you ever been in collection? YES NO
If yes, please explain in detail: _____
_____

_____

TREATMENT BUDGET PROPOSAL

Please type or clearly print (preferably in all caps).

Please consult the REACH financial office for the total projected cost of treatment and attach the official Patient Estimate document to your application. **Applications are considered incomplete without the Patient Estimate attached and will be withdrawn.**

Provide a financial summary for your treatment plan:

Physician	
Lab fees	
Anesthesia	
Facility fees	
Medication	
Genetic testing	
Egg / Sperm / Embryo donor	
Gestational carrier fees	
Cryopreservation (up to 1 year)	
Other:	
Other:	
Other:	
Total projected cost of treatment	

Provide an itemized budget for how you plan to pay for your treatment:

Personal contribution	
Insurance coverage/benefits	
Funds raised (friends/family, GoFundMe, etc.)	
Discounts (Compassionate Care Program, etc.)	
Other Financial Grants (Livestrong, etc.)	
Other:	
Amount of grant requested	

PERSONAL STATEMENTS

Please submit a statement written independently by EACH applicant indicating the potential importance of this donation for your family and why are you applying for this grant. Please include any extenuating circumstances (examples: job loss, financial struggle, medical diagnosis, life changes, etc.) that should be considered by the application reviews during the review process for The Samantha and Kyle Busch Bundle of Joy Fund.

Each statement should be 1000 words or less and no more than 2 pages. Typed and printed/attached statements are preferred. All statements must include the applicant's name, signature, and date.

Photos can be attached but please note that we cannot return any items submitted with the application.

APPLICANT #1 PERSONAL STATEMENT

Printed Name: _____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

APPLICANT #1 PERSONAL STATEMENT (Continued)

I attest that I wrote this statement myself and was truthful in my explanation.

_____Applicant #1 Signature/Date

APPLICANT #2 PERSONAL STATEMENT

Printed Name: _____

APPLICANT #2 PERSONAL STATEMENT (Continued)

I attest that I wrote this statement myself and was truthful in my explanation.

_____

Applicant #2 Signature/Date

CONSENT

By submitting this application and signing below, the applicant(s) understand and consent to the following (initial each statement and sign below):

1. I do hereby give The Samantha and Kyle Busch Bundle of Joy Fund, its agents and assigns, full permission, and authority to use, publish and display my name, voice and photograph or other likeness for advertising, promotion, charitable solicitation, or other related promotional purposes in any media without compensation. (Concessions can be made on a case-by-case basis).
_____ Applicant #1
_____ Applicant #2

2. Submitting this application does not in any way guarantee that we will receive The Samantha and Kyle Busch Bundle of Joy Fund grant.
_____ Applicant #1
_____ Applicant #2

3. We understand that we will not receive any money directly. The funds will be provided directly to the treatment providers (REACH) as a credit to our current account.
_____ Applicant #1
_____ Applicant #2

4. I acknowledge that the application reviewers will be receiving personal, medical, and financial information and I am assured that this information will not be shared with anyone outside of the Selection Committee.
_____ Applicant #1
_____ Applicant #2

5. If we are awarded The Samantha and Kyle Busch Bundle of Joy Fund donation that the money must be used within 12 months of receipt of the donation to our account at our treatment provider.
_____ Applicant #1
_____ Applicant #2

6. Should a refund be available due to services costing less than anticipated, services not being rendered, a shared risk cycle is unsuccessful and funds are reimbursed by a clinic or as a result of a tax refund for adoption, I understand that the refund will be returned to The Samantha and Kyle Busch Bundle of Joy Fund and that we, the applicants, shall not be entitled to any direct compensation or refund outside of our treatment needs.
_____ Applicant #1
_____ Applicant #2

7. If it is found that any information contained in this application was falsified, if the instructions were not followed, or if your family, fertility, or legal status changed following the submission of this application and The Samantha and Kyle Busch Bundle of Joy Fund was not notified of such a change, the donation money, if offered, may be rescinded, or forfeited depending on the specific circumstance at the discretion of the review committee.
_____ Applicant #1
_____ Applicant #2

8. The Samantha and Kyle Busch Bundle of Joy Fund has the right to confirm that applicants are in good standing with their current treatment provider.
_____ Applicant #1
_____ Applicant #2

9. I acknowledge that I may be subject to a criminal background check as a prerequisite to receive funding from The Samantha and Kyle Busch Bundle of Joy Fund.
_____ Applicant #1
_____ Applicant #2

10. The information contained in this application is truthful.
_____ Applicant #1
_____ Applicant #2

11. Should we be awarded a grant from The Samantha and Kyle Busch Bundle of Joy Fund, we grant permission for the following individuals to be contacted to plan a special surprise grant reveal:

Contact #1 Full Name: _____

Relationship to the Applicant: _____

Phone: _____

Email: _____

Contact #2 Full Name: _____

Relationship to the Applicant: _____

Phone: _____

Email: _____

_____
Applicant #1 Signature/Date

_____
Applicant #1 Printed Name

_____
Applicant #2 Signature/Date

_____
Applicant #2 Printed Name

AUTHORIZATION FORM

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Reproductive Endocrinology Associates of Charlotte (REACH) to disclose certain health information about me to The Samantha and Kyle Busch Bundle of Joy Fund.

This authorization permits the above-mentioned clinic to disclose health information about me (and my partner, if applicable) for the purpose of applying for a grant from The Samantha and Kyle Busch Bundle of Joy Fund.

Clinic Name: Reproductive Endocrinology Associates of Charlotte (REACH)

Address: 1524 E Morehead Street, Charlotte, NC 28207

Physician: _____

_____

Applicant #1 Signature/Date

_____

Applicant #1 Printed Name

_____

Applicant #2 Signature/Date

_____

Applicant #2 Printed Name

GRANT APPLICATION REVIEW COMMITTEE

Application Review Committee may include:

- A minimum of two (2) members of the REACH Clinic Staff.
- A minimum of two (2) members of the BOJF Board of Directors
- A minimum of two (2) members of the Staff of BOJF including but not limited to the founder, Samantha Busch.

Application review will take place within 6 weeks after the application window deadline.

Applicant will provide a contact name and information for the BOJF to begin planning a grant reveal should the applicant be eligible to receive a grant.

Grant reveal is estimated to be awarded within 60 days of the grant application window deadline.