Heartland Surrogacy

855-995-BABY
www.heartlandsurrogacy.com

Application for Services - *Gestational Carrier Candidate*

The information provided in this application will be used to determine your eligibility as a gestational carrier and to promote effective matches with Intended Parents. Please be as accurate and thorough as possible.

Personal Information

Legal Name *(Last, First, M.I.)*		Date of Birth
City	State	Occupation

(The information in this section is viewed by Heartland Surrogacy only.)

Street Address	Zip	County
Social Security #	Driver's License #	
Name as it appears on your birth certificate		
Place of birth	Email Address	
Home Phone	Cell Phone	
If applicable: Employer	Length of Employment	
Employer's Address	Employer's Phone	
Work Phone	Fax	
If applicable: Spouse/Partner's Legal Name	Date of Birth	
Social Security #	Driver's License #	
Cell Phone	Email Address	
Occupation	Employer	
Employer's Address	Employer's Phone	
What is the best way to contact you?		
When is the best time to contact you?		
Can we leave a message? *(If not, please provide an alternative)*		
Who is your OB provider?	Phone Number	
Address	Fax Number	

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How did you hear about us?	☐Medical Provider	☐Google	☐Facebook	☐Word of Mouth
	☐Twitter	☐Pinterest	☐Other ________________	

Matching Information

(The following information will be shared with intended parents.)

GENERAL

What name do you go by?				
What is your height?	Weight?	Race/Ethnicity?		
Are you a member of a Native American tribe?	☐*Yes, a registered member*	☐*Yes, a non-registered member*	☐*No*	
What is your relationship status?	☐*Single* ☐*Married*	☐*Divorced* ☐*Widowed*	☐*Separated*	☐*Engaged*
If applicable: How long have you been married?				
Have you experienced significant marital problems?	☐*Yes*	☐*No*		
If you are not married but you do have a partner, do you live together?	☐*Yes*	☐*No*		
If so, how long have you lived together?				
Do you have any children together?	☐*Yes*	☐*No*		
How many children do you have together? *(if applicable)*	Males:	Ages:	Females:	Ages:
Do you have biological children from another relationship?	☐*Yes*	☐*No*		
How long has your spouse/partner been employed? *(if applicable)*				
What is their highest level of education?	Year completed			
Has your spouse/partner ever been arrested?	☐*Yes*	☐*No*		
If yes, was there a conviction?	☐*Yes*	☐*No*		
If there was an arrest or a conviction, please explain:				
What is your highest level of education?	Year completed			
Are you a US citizen?	☐*Yes*	☐*No*		
Have you ever been arrested?	☐*Yes*	☐*No*		

	If yes, were you convicted?	☐ *Yes*	☐ *No*
	If you have been arrested and/or convicted, please explain:		
Do you feel your family is complete?		☐ *Yes*	☐ *No*
	Please explain:		
Do you currently practice a religion?		☐ *Yes*	☐ *No*
	If so, please specify:		

INCOME		
What is your current income?		
Please specify any additional income outside of work (including state or federal assistance):		
Are you currently receiving any form of public assistance?	☐ *Yes*	☐ *No*
If yes, please share what type:		
How many people do you support on this income, including yourself?		
What is your spouse/partner's income? *(if applicable)*		
Have you or your spouse/partner ever:		
had your wages garnished?	☐ *Yes*	☐ *No*
filed a petition for bankruptcy?	☐ *Yes*	☐ *No*
had a foreclosure?	☐ *Yes*	☐ *No*
had an eviction?	☐ *Yes*	☐ *No*

HEALTH		
Do you have health insurance?	☐ *Yes*	☐ *No*

Question			
If so, does it include maternity coverage?	☐Yes		☐No
To your knowledge, does it exclude surrogacy?	☐Yes	☐No	☐Unsure
Is your health insurance provided through a state agency or program?	☐Yes		☐No
Do you have any short-term disability insurance?	☐Yes		☐No
Has any life or health insurer refused to issue you an insurance policy?	☐Yes		☐No
If so, please explain:			
Do you have any allergies?	☐Yes		☐No
If so, please specify:			
Do you have any medical problems?	☐Yes		☐No
If so, please explain:			
List any serious illnesses or hospitalizations:			
List any surgeries you have had:			
List any medications you are taking and the reason for use:			
Have you ever been advised to have a medical procedure or test and not followed through?	☐Yes		☐No
If so, please explain:			
Are your immunizations up to date?	☐Yes		☐No
If not, please explain:			
Have you ever been seen by a professional for mental health issues?	☐Yes		☐No
If so, please explain:			
Have you ever been diagnosed with a mental health disorder?	☐Yes		☐No
If so, please explain:			
Have you ever experienced post-partum depression?	☐Yes		☐No

If so, please explain:	
Have your parents experienced any serious mental or physical health issues?	☐Yes ☐No
If so, please explain:	
Please list the cause of death and age of any deceased parents:	
What is your blood type and RH factor?	
Please describe any eating disorders you have had:	
What type of birth control are you currently using?	
How long have you used this method?	
Please list any hormones to which you have had a reaction:	
How many days are between day 1 of your period and day 1 of your next period?	
How many days do you bleed?	
Do you have any bleeding between periods?	☐Yes ☐No
How would you describe cramping during your periods?	☐Mild ☐Moderate ☐Severe
Have you ever had an abnormal pap smear?	☐Yes ☐No
If so, please explain:	
Please share any concerns about your monthly cycle:	
Do you have a sexual partner now?	☐Yes ☐No
Do you have more than one sexual partner?	☐Yes ☐No
Does your partner have other partners?	☐Yes ☐No
With whom have you had sexual contact?	☐Men ☐Women
How many partners have you had in the last 2 years?	
Have you had sexual contact with someone you did not know well?	☐Yes ☐No
What is your HIV status?	☐Positive ☐Negative ☐Unknown

What is your partner's HIV status?	☐*Positive*	☐*Negative*	☐*Unknown*
Have you ever tested positive for a sexually transmitted infection?	☐*Yes*		☐*No*
If so, please state when and which infection(s):			
Have you personally experienced rape, sexual assault, or any sexual or physical abuse?	☐*Yes*		☐*No*
If so, please explain:			
Have you ever used IV drugs?	☐*Yes*		☐*No*
Has your partner ever used IV drugs?	☐*Yes*		☐*No*
Have you received a blood transfusion outside of the US or prior to 1985?	☐*Yes*		☐*No*
How many pregnancies have you had?			

Number of live births:	Dates:
Number of miscarriages:	Dates:
Number of abortions:	Dates:
Number of still births:	Dates:

Please provide the following information for all deliveries: *(use additional pages if necessary)*

Date	Sex	Name	Weight	Vaginal or Cesarean?	Physical or emotional problems before or after delivery?

Did you need any medical intervention to conceive any of your children?	☐*Yes*	☐*No*
How long did it take to conceive each of your children?		

Has a doctor ever told you that you have a fertility issue?	☐Yes	☐No
Have you been told that future deliveries will need to be by C-section?	☐Yes	☐No
Do you have any children placed for adoption?	☐Yes	☐No
Have you given birth to a child with any birth defects?	☐Yes	☐No
Do any of your children have serious medical problems?	☐Yes	☐No
If so, please explain:		
Are your children's immunizations up to date?	☐Yes	☐No
If not, please explain:		
If any of your children are deceased, what was the age and cause of death?		
Are you currently breastfeeding?	☐Yes	☐No
If so, when do you plan to stop?		
Have you adopted any children?	☐Yes	☐No
Do you have any children not living with you?	☐Yes	☐No
If so, please explain:		
Do you smoke cigarettes?	☐Yes	☐No
Have you ever smoked cigarettes?	☐Yes	☐No
Does anyone in your house smoke cigarettes?	☐Yes	☐No
Do you drink alcohol?	☐Yes	☐No
Have you ever used illegal drugs or drugs not prescribed to you?	☐Yes	☐No
Have you ever had problems with alcohol or drug abuse?	☐Yes	☐No
If so, please explain:		
Has your partner ever used illegal drugs or drugs not prescribed to him/her?	☐Yes	☐No
Has your partner ever had problems with alcohol or drug abuse?	☐Yes	☐No
If so, please explain:		

Have you obtained a tattoo or body piercing in the last year?	☐ *Yes*	☐ *No*
Are you adopted?	☐ *Yes*	☐ *No*
Do you have any pets? *(please list)*		
How often do you wear your seatbelt?	☐ *Always* ☐ *Sometimes*	☐ *Never*
Do you have guns in your home?	☐ *Yes*	☐ *No*
If so, where are they kept?		
What do you use for transportation?	☐ *Car*	☐ *Public Transport*
Is your vehicle insured? *(if applicable)*	☐ *Yes*	☐ *No*
Do you have a valid driver's license?	☐ *Yes*	☐ *No*
Have you had any traffic violations in the last five years?	☐ *Yes*	☐ *No*
If so, please explain:		
How much caffeine do you consume on an average day?		
Are you willing to go completely without caffeine?	☐ *Yes*	☐ *No*

SURROGACY PROCESS		
Have you ever applied or are you currently applying to be a surrogate with any other agency or intended parent(s)?	☐ *Yes*	☐ *No*
If so, please explain:		
Have you ever applied and been told that you do not meet the criteria to be a carrier?	☐ *Yes*	☐ *No*
If so, please explain:		
Have you even been an egg donor?	☐ *Yes*	☐ *No*
Have you ever been a surrogate?	☐ *Yes*	☐ *No*

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If so, please describe your experience briefly:		
Do you have any plans to move out of state within the next year?	☐ *Yes*	☐ *No*
If so, please explain:		
What is the airport nearest to your home?		
How far away is it?		
Please tell us about the intended parents (IPs) you would be willing to work with:		
a heterosexual couple?	☐ *Yes*	☐ *No*
a same-sex couple?	☐ *Yes*	☐ *No*
a single male?	☐ *Yes*	☐ *No*
a single female?	☐ *Yes*	☐ *No*
IPs using an egg donor?	☐ *Yes*	☐ *No*
IPs using a sperm donor?	☐ *Yes*	☐ *No*
IPs who are HIV positive?	☐ *Yes*	☐ *No*
IPs with children?	☐ *Yes*	☐ *No*
IPs whose race is different from yours?	☐ *Yes*	☐ *No*
IPs whose ethnic background is different from yours?	☐ *Yes*	☐ *No*
IPs whose religious background is different from yours?	☐ *Yes*	☐ *No*
IPs living in a different state?	☐ *Yes*	☐ *No*
Please list who you would *not* be interested in working with, if not listed above:		

Please list the qualities you would like to see in the intended parent(s):			
Are you willing to receive immunizations during pregnancy?		☐*Yes*	☐*No*
Would you be willing to undergo amniocentesis or other diagnostic testing if deemed necessary?		☐*Yes*	☐*No*
Are you willing to let the IPs make decisions about abortion and reduction? Please explain. *(If not, please contact our agency before submitting your application to ensure we have availability in our program.)*			
Would you allow the IPs to attend doctor's appointments with you?		☐*Yes*	☐*No*
Would you allow the IPs in the delivery room?	☐*Mother(s)*	☐*Father(s)*	☐*None*
Would you allow the hospital to know that you are not the biological mother?		☐*Yes*	☐*No*
Would you allow the IP's names to be on the birth certificate?		☐*Yes*	☐*No*
If requested, would you be willing to pump, freeze, and ship breast milk to the IPs?		☐*Yes*	☐*No*
How do you feel about carrying twins?			
Although they are uncommon, how do you feel about carrying triplets?			
How do you feel about reducing a surrogacy pregnancy from 3 to 2, or 3 to 1?			
How many embryos are you willing to have transferred at once?			
How many embryo transfers are you willing to undergo to achieve a pregnancy?			
Are you willing to travel for surrogacy-related procedures/appointments?		☐*Yes*	☐*No*
Are you able to obtain childcare for any children living with you?		☐*Yes*	☐*No*

How do you feel about taking daily medications/injections?		
How would your daily life be affected if you physician recommended bed rest?		
Would you consider carrying a second child for the IPs within 2-5 years of the first surrogacy?	☐ *Yes*	☐ *No*
What kind of support would you like from the IPs during the pregnancy?		
How much contact would be appropriate from the IPs during the pregnancy?		
What is your preferred method of contact with the IPs during the surrogacy journey? Choose all that apply. □ Phone call □ Text message □ Email □ Facetime or Skype (video chatting) □ Postal Mail □ Other: ______		
How much contact or information about the child do you want after the birth?		
Please explain any timeline you may have for becoming a gestational carrier *(if applicable)*:		

Please explain your understanding of what it means to be a gestational carrier:	
Please rate the following reasons for becoming a gestational carrier in order of importance to you (1=most important):	
I like being pregnant but don't want any more children of my own.	☐1 ☐2 ☐3 ☐4
I could really use the money.	☐1 ☐2 ☐3 ☐4
It would be a joy to carry and have a child for someone else.	☐1 ☐2 ☐3 ☐4
Other: *(please specify)*	☐1 ☐2 ☐3 ☐4
Please list any concerns you may have about becoming a gestational carrier:	
Are your parents, siblings, friends, and coworkers supportive of your decision to be a surrogate?	☐*Yes* ☐*No*
Please describe how your partner feels about your decision:	

Please give a brief description of yourself and your greatest qualities:

COMPENSATION

We encourage you to consider your compensation amount carefully, keeping in mind that it may play a role in how quickly you are matched with potential intended parents. We also suggest speaking with a tax professional about possibly paying taxes on your compensation.

Singleton:

Multiples:

LETTER TO INTENDED PARENTS

Please write a letter to the intended parents that includes information about yourself, your family, and how you decided to become a gestational carrier. Attach it to this application.

ATTACHMENTS

With your application, please include a copy of your and your partner's driver's license, a copy of your social security card, and photos of you and your family. One photo of you must be full length. Please also include a copy of your insurance card, front and back, and your policy book. Please start requesting that your OB/GYN records and letter of clearance from your OB be sent to our agency, as this usually takes some time.

Statement of Understanding

In completing and submitting this application to Heartland Surrogacy (Agency), you understand that there is no guarantee that you will be accepted into the program and matched with intended parents. You understand that no identifying information, other than first names, will be released to intended parents until after a contract has been signed by both parties.

You agree to sign releases to for Agency to obtain and verify your medical and psychological information, including, but not limited to, a psychological evaluation that was done regarding surrogacy. The information provided to the Agency may be used to accept and/or exclude you from a program in Agency's

sole and absolute discretion. In addition, you agree to allow the Agency to communicate with your OB/Gyn provider. By signing below, you agree that the information and statements made in this application are correct and complete to the best of your knowledge. You promise to update your information if something changes. You understand that if any false, misleading or incomplete information is provided, Heartland Surrogacy may refuse you acceptance into the program or cease to continue to work with you. You agree that any documents drafted on your behalf are property of Heartland Surrogacy and are not to be disclosed or distributed.

Surrogate Signature ______________________________________ Date _____________

Partner's Signature _______________________________________ Date _____________