

**IMPORTANT INSTRUCTIONS:** Before filling out this form,  
 SAVE AS on your Device  
 Open saved document on your device and complete



## Intended Parents Application and Questionnaire

Please type your answers in the highlighted fields.

\*\*\*What fertility clinic will be doing the monitoring for the Gestational Carrier? If you don't know yet, please let us know as soon as it's determined.

<b>BASIC INFORMATION</b>		
Today's Date:		
Family Name : (first, last of both parents)	1.	2.
Home Address:		
City, State and zip code		
Email address	1.	2.
Cell Phone No.	1.	2.
Do you have any prior involvement with A New Beginning?	Yes _____ No _____	
If so, which program	Infant Adoption Foster-Adoption Birthparent services	International Adoption Private Adoption Other: _____
Did you complete the program?	Yes _____ No _____	
Total Household Income		
Marital Status		
Date of Marriage/Partnership:		
How long have you been in this relationship?		

**Why have you selected surrogacy to build your family?**

[Redacted area for response]

**Why did you select A New Beginning's Surrogacy Program?**

[Redacted area for response]

**How have you prepared yourself for your surrogacy journey? Please address feelings around infertility, how you have educated yourself, and if you have discussed, how you will talk to your child about your gestational carrier as well as donor(s).**

[Redacted area for response]

**Children currently living inside the home**

Name	Birth Date	Relationship	Biological	Adopted	Surrogacy

**Other Residents (please include any roommates, adult children, etc.)**

Name	Birth Date	Relationship

**Children living outside of the home**

Name	Birth Date	Living Situation

**To be completed by Applicant 1:** The following questions help provide information to be included in future contracts and legal documents.

**Applicant 1: Information**

Last Name, First Name MI:			
Maiden name or previous names:			
Social Security Number:		Sex:	
Birth date:		Age:	
Birth Place			
How long have you lived in current State/Country?			
List other states/countries in which you have lived in the past 10 years.	Country/State	How long did you live there?	
<b>EMPLOYMENT</b>			
Present Employer?			
Type of Business			
Your Position		Length of employment:	
Business phone			
Work Hours			
May we contact you at work?	Yes _____ No _____		
<b>RELATIONSHIP HISTORY</b>			
Were you previously married?	Yes _____ No _____		
Former Spouse's Name			
Date of Marriage:		Date marriage ended:	
Method of ending Marriage			
Reason for dissolving marriage			

<b>ADDITIONAL INFORMATION</b>	<i>If you answer "yes" to any of these questions, please explain in detail below or on a separate sheet, be as thorough as possible and include information such as dates and outcomes.</i>
Have you declared bankruptcy?	Yes _____ No _____ Dates:
Have you ever received treatment for alcohol or drug use?	Yes _____ No _____ Dates:
Have you ever filed for a protective or restraining order or had a protective or restraining order filed against you?	Yes _____ No _____ Dates:
Have you ever been in a violent relationship?	Yes _____ No _____ Dates:
Have you ever been psychiatrically hospitalized?	Yes _____ No _____ Dates:
Do you have any medical conditions for which you have had treatment in the past 5 years?	Yes _____ No _____ Dates:
Do you have a physical or emotional condition that effects your functioning or may affect your life span?	Yes _____ No _____ Details:
Have you ever been arrested for a misdemeanor or felony?	Yes _____ No _____ Dates:

I certify the information provided on this form is accurate and true to the best of my knowledge.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed by Applicant 2** The following questions help provide information to be included in future contracts and legal documents.

**Applicant 2: Information**

Last Name, First Name MI:			
Maiden name or previous names:			
Social Security Number:		Sex:	
Birth date:		Age:	
Birth Place			
How long have you lived in current State/Country?			
List other states/countries in which you have lived in the past 10 years.	Country/State	How long did you live there?	
<b>EMPLOYMENT</b>			
Present Employer?			
Type of Business			
Your Position		Length of employment:	
Business phone			
Work Hours			
May we contact you at work?	Yes _____ No _____		
<b>RELATIONSHIP HISTORY</b>			
Were you previously married?	Yes _____ No _____		
Former Spouse's Name			
Date of Marriage:		Date marriage ended:	
Method of ending Marriage			
Reason for dissolving marriage			

<b>ADDITIONAL INFORMATION</b>	<i>If you answer "yes" to any of these questions, please explain in detail below or on a separate sheet, be as thorough as possible and include information such as dates and outcomes.</i>
Have you declared bankruptcy?	Yes _____ No _____ Dates:
Have you ever received treatment for alcohol or drug use?	Yes _____ No _____ Dates:
Have you ever filed for a protective or restraining order or had a protective or restraining order filed against you?	Yes _____ No _____ Dates:
Have you ever been in a violent relationship?	Yes _____ No _____ Dates:
Have you ever been psychiatrically hospitalized?	Yes _____ No _____ Dates:
Do you have any medical conditions for which you have had treatment in the past 5 years?	Yes _____ No _____ Dates:
Do you have a physical or emotional condition that effects your functioning or may affect your life span?	Yes _____ No _____ Details:
Have you ever been arrested for a misdemeanor or felony?	Yes _____ No _____ Dates:

I certify the information provided on this form is accurate and true to the best of my knowledge.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Gestational Carrier and Process Questionnaire

The following questions will help us understand your expectations as you begin the match process to ensure a positive match and experience for both you and your Gestational Carrier. The questions will enable us to support you through your surrogacy journey. If there are questions that you have not thought about or are unsure of, please leave blank and your Surrogacy Specialist will discuss with you at your intake meeting. You may not know the answer to some of the questions until you are matched with Gestational Carrier. Please leave those questions blank. These questions will also be used to develop the contract between you and your Gestational Carrier. As answers may change after you are matched, you will have the opportunity after your match to answer questions again. Please use this questionnaire as a tool to think about possible scenarios and to clarify your hopes and expectations.

<b>MEDICAL QUESTIONS</b>	
Will the first cycle be a Fresh cycle or Frozen?	Fresh Frozen
What is the source of the ovum?	Intended Mother Anonymous Ovum Donor Known Donor: _____
What is the source of the sperm?	Intended Father Anonymous Sperm Donor Known Donor: _____
How many IVF cycles are you willing to undergo to achieve a pregnancy?	
How many NF cycles do you want the Gestational Carrier to commit to?	

How long would you anticipate waiting between cycles?	
Are you having, or did you have the Preimplantation Genetic Diagnosis (PGD) or Preimplantation Genetic Screening (PGS) procedure performed on your embryo?	PGD PGS
Do you intend to have an amniocentesis or other genetic testing procedures?	Yes No
If not, will you have an amniocentesis if the doctor recommends the procedure?	Yes No
Are you willing to have the Gestational Carrier carry triplets given that a triplet pregnancy will likely require significant amounts of bedrest and additional compensation?	Yes No
What type of birth do you anticipate the Gestational Carrier having?	Vaginal birth C-Section Either/No Preference
Do you want the Gestational Carrier to be induced so that you can be at the birth if necessary?	Yes No
At which hospital do you plan to have the Gestational Carrier deliver?	
At birth, to whom is the child to be given?	
For a vaginal delivery, who may be present in the delivery room?	
For a C-Section delivery, if only one person is allowed, what is your expectation about who will be in the operating room with the Gestational Carrier?	
<b>IP/GC RELATIONSHIP QUESTIONS</b>	
How would you like to communicate with the Gestational Carrier during the pregnancy?	Phone Text E-mail

	Skype/Zoom/Facetime
How frequently would you like to communicate?	Daily Weekly Bi-Weekly Monthly
What frequency of communication would you like to have after the birth of the child?	
Would you be willing to share pictures of the child with the GC?	
How do you feel about the GC sharing her experience on Social Media?	
<b>GC HEALTH EXPECTATIONS</b>	
What are your expectations regarding nutritional habits during the pregnancy?	
Would you like the Gestational Carrier to avoid certain foods during the pregnancy?	
How is your expectation of the pregnancy different if there is a twin pregnancy versus a singleton pregnancy?	
What are your thoughts in regard to the Gestational Carrier consulting with a mental health provider during the course of the pregnancy?	
It is common for the Gestational Carrier to feel a loss after delivery if they have developed a friendship with the intended parents and have had considerable attention from the intended parents, medical providers and other support staff throughout the pregnancy. Additionally, a	

<p>core human need of being needed for the development and delivery of the child has been fulfilled for the carrier. What are your expectations about what support could be provided for the carrier (counseling, consistent communication with GC and/or pictures for the first month)?</p>	
<p>If irreconcilable differences manifest during the pregnancy which threaten or terminate your marital relationship, what are your expectations with regard to the continuation of the pregnancy?</p>	
<p>In the event of death or disability of both intended parents prior to the birth, what are your expectations with regard to who will take custody and eventual guardianship of the child? If you have one designee who will take custody and guardianship, please provide their full legal name and contact information.</p>	
<p><b>HEALTH INSURANCE</b></p>	
<p>Have you identified the supplemental insurance policy you will be providing for your Gestational Carrier? If so, who is the provider?</p>	<p>Yes No If yes, list provider: _____</p>
<p><b>GESTATIONAL CARRIER COMPENSATION</b></p>	
<p>Do you want the Carrier to pump her breast milk?</p>	<p>Yes No If yes, how long? _____</p>

Feel free to write any concerns or discuss any issues that have not been addressed or adequately covered in this questionnaire.

---

---

---

---

---

**Signatures and Acknowledgment:**

Upon receipt of this completed application and questionnaire, an application intake meeting will be scheduled. After the intake meeting is completed, you will be eligible to begin the match process OR if you have already matched with a Gestational Carrier the steps will be taken to move forward with the process.

A New Beginning does not discriminate based on race, color, national origin, gender, age, religion, marital status, sexual orientation, physical or mental disability, political affiliation, or any other statute protected by law.

Thank you in advance for your thorough completion of this questionnaire.

Legal Signature of Applicant 1:	Date:
Legal Signature of Applicant 2:	Date:

**IMPORTANT:**  
MUST save this document on your desktop.  
To Submit, attached this completed document to [info@anewbeginningsurrogacy.org](mailto:info@anewbeginningsurrogacy.org)