LIVESTRONG fertility

Criteria and Application for Men

RETURN COMPLETED FORM VIA FAX OR EMAIL TO

LIVE**STRONG** Foundation ATTN LIVE**STRONG** Fertility FAX 512.309.5515 EMAIL Cancer.Navigation@LIVE**STRONG**.org

 ${\it Made \ possible \ by \ participating \ reproductive \ endocrinologists \ and \ EMD \ Serono, \ Inc.}$

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GOAL

The goal of LIVE**STRONG** Fertility is to increase access to fertility preservation services and treatments for qualified men who are diagnosed with cancer during their reproductive years.

We are proud to offer assistance to qualified male applicants by providing access to discounted sperm banking services through the generous support of participating sperm banking facilities.

OVERVIEW

LIVE**STRONG** Fertility does not grant direct financial contributions to individuals. Instead, the LIVE**STRONG** Foundation has partnered with key organizations to increase access to procedures and treatments intended to preserve the possibility of fertility for qualified cancer patients whose medical treatments present the risk of infertility and who meet the criteria set forth below. *For a list of participating facilities, please call 855.220.7777.*

WHAT IS INCLUDED?

LIVE STRONG Fertility helps reduce the cost of sperm banking services which include but may not be limited to:

- One on-site collection of a sperm specimen at a participating location or one off-site collection of a sperm specimen through a sperm banking by mail service
- · Analysis, processing and freezing of one sperm specimen

WHAT IS NOT INCLUDED?

While we understand the importance of other fertility preservation and parenthood options, this program only covers sperm cryopreservation. The reduced cost offered by the reproductive center does not include many of the additional costs of preparing for or going through treatment.

THESE ADDITIONAL COSTS COULD INCLUDE, BUT ARE NOT LIMITED TO:

» Laboratory work performed	$ ightarrow Long-term storage^*$
on your behalf	» Implantation procedures

- » Infectious disease testing » Travel to fertility centers
- » Doctors' fees *Discounts on long-term storage may be available.

The participant or his insurance company will have to bear the costs of services provided by entities or individuals not affiliated with LIVE **STRONG** Fertility, including, but not limited to, the costs associated with the related services noted above. It is important to know what those costs are and to plan accordingly.

Prior to banking sperm, all program participants are required to have infectious disease blood tests. Patients must contact the participating sperm bank to find out which blood tests are required and when the tests must be conducted and sent to the facility. The participant's oncologist may conduct the tests or the tests can be performed on-site at the sperm bank at an additional cost. If the test results are not received, the participant may be charged additional quarantine fees.

If a physician determines that treatments or medications other than the services provided by the sperm bank are necessary, the participant will be responsible for the cost of such treatments and medications.

LIVE **STRONG** Fertility does not cover the cost of oncology services or any associated expenses incurred during cancer treatments. Please keep in mind that the Foundation is not a medical provider; all program participants acknowledge and agree that the Foundation shall not be liable for any aspect of their current and future treatment. All cancer patients should discuss the risks, side effects, time requirements and other aspects of all treatment options with their physicians before selecting the most appropriate course of care.

For more information about LIVE**STRONG** Fertility or cancer navigation services at the Foundation which can help anyone affected by cancer, contact us at 855.220.7777.

How to Apply

ELIGIBILITY CRITERIA

The Foundation selects participants for LIVE **STRONG** Fertility based on the following criteria. Only patients who meet all of the following criteria will be accepted.

- \Box U.S. citizen or permanent resident
- □ Annual adjusted gross household income is less than or equal to \$75,000 (if single) or \$100,000 (if married)
- \Box Diagnosis of certain types of cancer
- □ Oncologist has determined that the recommended cancer treatments present the risk of infertility
- Oncologist has determined that the treatments and associated medications are medically appropriate
- □ No contraindication to fertility preservation and/or fertility treatments as determined by an oncologist
- □ Uninsured or denied insurance coverage for the treatments and procedures required for sperm cryopreservation
- □ Individual has not previously received benefits from LIVE**STRONG** Fertility

Please contact us directly for further clarification regarding any of the eligibility requirements listed above.

APPLICATION REQUIREMENTS

Complete the following forms with the help of your medical team and make a copy for your records. *Please print clearly and submit your completed application to the Foundation via mail, fax or email to:*

LIVE**STRONG** Foundation ATTN LIVE**STRONG** Fertility 2201 East Sixth Street Austin, TX 78702 FAX 512.309.5515 EMAIL Cancer.Navigation@LIVE**STRONG**.org

Please note: Your application will not be fully processed if any of the following information has not been received:

- Completed Patient Authorization and Consent Form
- Completed Oncologist Referral and Certification Form
- Copy of your 1040 Federal Tax Return Form from the most recent year

If you did not file taxes, contact us at 855.220.7777 for more information.

NEXT STEPS

The Foundation will notify applicants of approval or denial within one-two business days after all required forms are received. LIVE**STRONG** Navigators contact individuals with open applications once a week to discuss pending forms. If we have not contacted you within one-two business days after the submission of required forms, please contact us to verify that your forms have been received. All approved applicants will receive a phone call and an approval letter via email, when possible, to outline the next steps. Pending applications will be closed after six weeks if the Foundation does not receive all required forms. To reopen your application, you will need to contact the Foundation at 855-220-7777.

Patient Authorization and Consent Form

Complete all fields in the following form and keep a copy for your records.

Incomplete applications will not be processed.

Note: You should discuss the risks, side effects and other aspects of all treatment options with your health care team before selecting the best course of treatment for you. If at any time your health care team has advised you or does advise you to seek treatment for cancer immediately, it is the position of the LIVE **STRONG** Foundation that you should not delay your treatments in order to receive these services.

PERSONAL INFORMATION

LAST NAME	FIRST		MIDDLE	
ADDRESS	CITY		STATE	ZIP CODE
SOCIAL SECURITY	DATE OF BIRTH	RACE/ETHNICITY	CANCER	ТҮРЕ
EMAIL	PRIMARY PHONE		SECONDARY PHON	ΙE

- □ I give the LIVE**STRONG** Foundation permission to speak with another party regarding my LIVE**STRONG** Fertility application (e.g., parent/guardian, significant other, friend).
- □ I am a minor or have a secondary contact managing my application for medical or personal reasons. I understand the Foundation will contact my secondary contact first.

NAME	RELATION	PRIMARY PHONE
EMAIL ADDRESS		

INSURANCE INFORMATION

COMPANY NAME	GROUP NUMBER	POLICY NUMBER

TELEPHONE NUMBER

 \Box Uninsured

FINANCIAL INFORMATION

Average three-year annual household income

I certify that my yearly income or three-year income average is:

- □ Equal to or less than \$75,000 (for single applicants)
- □ Equal to or less than \$100,000 (for married applicants)

CONFIRM

- □ I have included my 1040 Federal Tax Return Form from the most recent year with this application. When speaking to the IRS, all references to LIVE**STRONG** Fertility should be made by stating that they are services administered by the LIVE**STRONG** Foundation.
- □ I am currently unemployed and have been unemployed for a consecutive period of six (6) months prior to the date of this application. If I cannot provide sufficient proof of unemployment by copy of my most recent unemployment benefit claims statement or payment, I authorize the LIVE**STRONG** Foundation to reasonably verify my unemployment status as part of the income verification process for the purposes of this application only.

SPERM BANK INFORMATION

CLINIC NAME

CITY

Patient Authorization and Consent Form

APPLICANT CERTIFICATION AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that the information provided in this application is complete and accurate. I authorize the release of the information contained in this application. I understand it is for the sole use of the LIVE STRONG Foundation, its representatives and/ or agents in order to assess my eligibility for participation in LIVE STRONG Fertility. I authorize the Foundation, its representatives and/or agents to request and obtain from my physicians and any insurer any medical or other patient information related to my treatment for cancer and infertility. I also authorize the Foundation, its representatives and/ or agents to share the information contained herein with participating sperm banks in order to secure assistance for me under LIVESTRONG Fertility. I agree to immediately inform the Foundation if my income or insurance status changes and to provide any documentation that the Foundation requests to verify the same. I further authorize these parties to contact me directly, if necessary, to process this application. I understand that my application for assistance from LIVE STRONG Fertility does not guarantee that assistance will be provided. I understand that eligibility for LIVE STRONG Fertility is subject to approval under the criteria and requirements set forth herein and that the Foundation reserves the right to change or terminate LIVE STRONG Fertility without prior notice. I agree to abide by this certification and authorization throughout my participation in LIVESTRONG Fertility and to notify the Foundation if aspects of my certification and authorization form are no longer applicable. I understand that the Foundation is not itself a medical provider, and by submitting this application with my signature below, I acknowledge and agree that the Foundation shall not be liable for any aspect of my current and future treatment. I understand that there are no guarantees that the procedures intended to assist in preserving fertility will be successful in preserving my fertility. I also understand the success rates of the procedures and I agree that the Foundation shall not be liable for any treatment failure.

I assume all risk of and financial responsibility for any loss or injury related directly or indirectly to my participation in the program and agree to indemnify and hold the Foundation harmless from and against any and all costs, claims, demands, charges, liabilities, obligations or fees incurred or suffered by me as a result of, or arising out of, my participation in LIVE**STRONG** Fertility except for claims resulting wholly from the gross negligence of the Foundation.

I have discussed with my physicians the risks, side effects and other aspects of sperm banking before selecting it as a course of treatment for me.

By signing below, I certify that i have completely and accurately disclosed, and at all times will completely and accurately disclose, my medical history to all of my health care providers, including but not limited to, any oncologist. I understand that the agreements under LIVE**STRONG** Fertility shall be construed and interpreted in accordance with the laws of the State of Texas without regard to its conflicts of law provisions.

PATIENT SIGNATURE	DATE
PARENT/GUARDIAN SIGNATURE	DATE

(If patient is under age 18)

Oncologist Referral and Certification Form

Complete all fields in the following form and keep a copy for your records. Incomplete applications will not be processed.

Note: You should discuss the risks, side effects and other aspects of all treatment options with your patient before recommending the best course of treatment. If at any time you have advised or do advise your patient to seek treatment for cancer immediately, it is the position of the LIVESTRONG Foundation that the patient should not $delay \, treatments \, in \, order \, to \, receive \, these \, services.$

PATIENT INFORMATION

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LAST NAME	FIRST	MIDDLE	
DOB	PRIMARY PHONE		
PHYSICIAN INFORMATI	ON		
LAST NAME	FIRST	MI	TITLE
DEA/NPI NUMBER	CLINIC/HOSPITAL		
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE	FAX	EMAIL	
NURSE OR CLINIC CONTACT NAM	AE (IF DIFFERENT FROM PHYSICIAN)		
PHONE	FAX	EMAIL	
TREATMENT INFORMAT	ION		
CANCER TYPE			
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