



## Criteria and Application *for Men*

RETURN COMPLETED FORM  
VIA FAX OR EMAIL TO

**LIVESTRONG** Foundation  
ATTN **LIVESTRONG** Fertility  
FAX 512.309.5515  
EMAIL [Cancer.Navigation@LIVESTRONG.org](mailto:Cancer.Navigation@LIVESTRONG.org)

*Made possible by participating sperm banking facilities.*

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#### GOAL

The goal of LIVESTRONG 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

LIVESTRONG Fertility does not grant direct financial contributions to individuals. Instead, the LIVESTRONG 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?

LIVESTRONG 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 sperm banking facility 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 on your behalf*
- » *Infectious disease testing*
- » *Doctors' fees*
- » *Long-term storage\**
- » *Implantation procedures*
- » *Travel to fertility centers*

*\*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 LIVESTRONG 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.

LIVESTRONG 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 LIVESTRONG 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 **LIVESTRONG** Fertility based on the following criteria. Only patients who meet all of the following criteria will be accepted.

- U.S. citizen or permanent resident*
- Annual adjusted gross household income is less than or equal to \$90,000 (if single) or \$115,000 (if married)*
- Diagnosis of cancer*
- Oncologist has determined that the recommended cancer treatments present the risk of infertility*
- Individual has not yet started fertility-damaging cancer treatments*
- Oncologist has determined that the treatments and associated medications are medically appropriate*
- Uninsured or limited insurance coverage for the treatments and procedures required for sperm cryopreservation*
- Individual has not previously received benefits from **LIVESTRONG** 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:*

**LIVESTRONG** Foundation  
ATTN **LIVESTRONG** Fertility  
2201 East Sixth Street Austin, TX 78702  
FAX 512.309.5515 EMAIL Cancer.Navigation@**LIVESTRONG**.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 by phone within one–two business days of receipt of all required forms.\**
- » *All approved applicants will receive a phone call and an approval letter via email, when possible, to outline the next steps.*

\*If we have not contacted you within one–two business days of receipt of all required forms, please contact us to verify that your forms have been received. Applications will be closed after six weeks. To reopen your application, you will need to contact the Foundation at 855.220.7777.

# Patient Authorization and Consent Form

1 of 2

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 LIVESTRONG 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 TYPE

EMAIL PRIMARY PHONE SECONDARY PHONE

- I give the LIVESTRONG Foundation permission to speak with another party regarding my LIVESTRONG 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

- 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 \$90,000 (for single applicants)
- Equal to or less than \$115,000 (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 LIVESTRONG Fertility should be made by stating that they are services administered by the LIVESTRONG 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 LIVESTRONG 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 STATE PHONE

# 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 **LIVESTRONG** Foundation, its representatives and/ or agents in order to assess my eligibility for participation in **LIVESTRONG** 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 **LIVESTRONG** Fertility does not guarantee that assistance will be provided. I understand that eligibility for **LIVESTRONG** Fertility is subject to approval under the criteria and requirements set forth herein and that the Foundation reserves the right to change or terminate **LIVESTRONG** 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 **LIVESTRONG** 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.

I understand that the Foundation is authorized as a “business associate” under 45 CFR 160.103 (in the act commonly known as “HIPAA”) and that as a business associate, health providers are allowed to disclose my protected health information to the Foundation based on the written assurances made by the Foundation to the health provider that the information will only be used for the purposes of **LIVESTRONG** Fertility, that the information will be safeguarded from misuse, and that the Foundation will help the health provider comply with their HIPAA duties.

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 **LIVESTRONG** 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

1 of 1

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

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_  
DOB \_\_\_\_\_ PRIMARY PHONE \_\_\_\_\_

## PHYSICIAN INFORMATION

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ TITLE \_\_\_\_\_  
DEA/NPI NUMBER \_\_\_\_\_ CLINIC/HOSPITAL \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
PHONE \_\_\_\_\_ FAX \_\_\_\_\_ EMAIL \_\_\_\_\_  
NURSE OR CLINIC CONTACT NAME (IF DIFFERENT FROM PHYSICIAN) \_\_\_\_\_  
PHONE \_\_\_\_\_ FAX \_\_\_\_\_ EMAIL \_\_\_\_\_

## TREATMENT INFORMATION

CANCER TYPE \_\_\_\_\_

### TREATMENT PLAN *(check all that apply)*

- Surgery to the reproductive area, please explain*       *Chemotherapy, please explain*  
 *Radiation to the brain or reproductive area, please explain*       *Other, please explain*

## TREATMENT TIMELINE

*(should fall after completion of fertility treatment)*

ESTIMATED START DATE \_\_\_\_\_ ESTIMATED TREATMENT DURATION \_\_\_\_\_

### FOR THE FOLLOWING QUESTION, CHECK YES OR NO.

*Answer is required; incomplete answers will delay processing.*

Does your intended treatment plan present a risk that the patient may become infertile?

- Yes*       *No*

*The Foundation is not itself a medical provider, and you, the treating physician, acknowledge and agree that the Foundation shall not be liable for any aspect of the treatment of the patient you have referred to us for participation in the LIVESTRONG Fertility.*

ONCOLOGIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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