FERTILE HOPE FOR MEN

Criteria and Application

LIVESTRONG fertileHOPE

Made possible by participating sperm banks and fertility centers

Last Update 8/12

PROGRAM OVERVIEW

Goal
Cancer patients have little opportunity to save for the high costs of cancer treatment, let alone budget for procedures or treatments intended to preserve the possibility of conceiving with their own sperm. Yet there is only a small window of opportunity between diagnosis and treatment during which cancer patients may pursue these options, and the upfront costs are often prohibitive. The goal of Fertile Hope for Men is to increase access to such procedures and treatments for qualified men who are diagnosed with cancer in 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
Fertile Hope does not grant direct financial contributions to individuals, but instead has partnered with key organizations to increase access to procedures and treatments intended to preserve the possibility of fertility for certain 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 1-855-220-7777.

What is covered?
This program helps reduce the cost of sperm banking.

The services that are available at reduced cost 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 the Live:On sperm banking by mail service
- Analysis, processing and freezing of one sperm specimen

Discounts on storage or additional specimens may be available.

What is not covered?
While we understand the importance of other fertility preservation and parenthood options, this program only covers sperm banking. The reduced cost offered by the sperm bank does not include many of the ancillary costs of preparing for, going through or storage after treatment.

These additional costs could include, but are not limited to:
- Laboratory work performed on your behalf
- Doctor's fees
- Long-term storage
- Implantation procedures

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

Contact: The Lance Armstrong Foundation; attn: Fertile Hope; 2201 East Sixth Street; Austin, TX 78702; fax: 512-857-0164; cancer.navigation@livestrong.org
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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.

Some of the fertility preservation technologies discounted by this program are only available in major metropolitan areas. We will make our best effort to refer patients to the nearest participating facility, but the program does not cover the cost of travel.

This program does not cover the cost of oncology services or any associated expenses incurred during cancer treatments. Please keep in mind that the Lance Armstrong 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 this program or cancer navigation services at the Foundation, which can help anyone affected by cancer, contact us at 855-220-7777.

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HOW TO APPLY

Eligibility Criteria
Applications for this program are reviewed based on the following criteria. Only people who meet all of the following criteria will be accepted.

- U.S. citizen or permanent resident
- Annual household income is less than or equal to $75,000 (if single) or $100,000 (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.
- 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 banking
- Individual has not previously been approved for the program

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

Application Requirements
Please 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:

The Lance Armstrong Foundation
Attn: Fertile Hope
2201 East Sixth Street Austin, TX 78702
Fax: 512-857-0164
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 by phone, mail and/or email within 1–2 business days, of receipt of all required forms. If we have not contacted you within that time frame, please contact us to verify receipt. All approved applicants will receive an approval letter outlining next steps.

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PATIENT AUTHORIZATION AND CONSENT FORM

COMPLETE ALL THE 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 PHYSICIANS BEFORE SELECTING THE BEST COURSE OF TREATMENT FOR YOU. IF AT ANY TIME YOUR PHYSICIANS HAVE ADVISED YOU OR DO ADVISE YOU TO SEEK TREATMENT FOR CANCER IMMEDIATELY, IT IS THE POSITION OF THE LANCE ARMSTRONG FOUNDATION THAT YOU SHOULD NOT DELAY YOUR TREATMENTS IN ORDER TO PARTICIPATE IN THIS PROGRAM.

PERSONAL INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

STREET ADDDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY _____ DATE OF BIRTH _____ RACE/ETHNICITY _____

CANCER TYPE _____ EMAIL _____

PRIMARY PHONE _____ SECONDARY PHONE _____

☐ I GIVE THE LANCE ARMSTRONG FOUNDATION PERMISSION TO SPEAK WITH ANOTHER PARTY REGARDING MY FERTILE HOPE APPLICATION (E.G., PARENT/GUARDIAN, SIGNIFICANT OTHER, FRIEND).

NAME _____ RELATION _____ PRIMARY PHONE _____

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 $75,000 (FOR SINGLE APPLICANTS)
- ☐ EQUAL TO OR LESS THAN $100,000 (FOR MARRIED APPLICANTS)

CONFIRM

- ☐ I HAVE SENT IN MY 1040 FEDERAL TAX RETURN FORM FROM THE MOST RECENT YEAR.

  WHEN SPEAKING TO THE IRS, ALL REFERENCES TO FERTILE HOPE SHOULD BE MADE BY STATING THAT IT IS A PROGRAM ADMINISTERED BY THE LANCE ARMSTRONG 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 LANCE ARMSTRONG 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 NUMBER _____

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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 Lance Armstrong Foundation, its representatives and/ or agents in order to assess my eligibility for participation in the Fertile Hope program. 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 the Fertile Hope program. 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 Fertile Hope does not guarantee that assistance will be provided. I understand that eligibility for Fertile Hope is subject to approval under the criteria and requirements set forth herein and that the Foundation reserves the right to change or terminate this program without prior notice. I agree to abide by this certification and authorization throughout my participation in Fertile Hope 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 Fertile Hope 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 Fertile Hope 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 UNDER AGE 18)

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ONCOLOGIST REFERRAL & CERTIFICATION FORM

COMPLETE ALL THE 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 LANCE ARMSTRONG FOUNDATION THAT THE PATIENT SHOULD NOT DELAY TREATMENTS IN ORDER TO PARTICIPATE IN THIS PROGRAM.

PATIENT INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

DOB _____ PRIMARY PHONE _____

PHYSICIAN INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

TITLE _____ STATE LICENSE NUMBER _____ FULL NAME OF CLINIC OR HOSPITAL _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ EMAIL _____

HOSPITAL OR CLINIC CONTACT NAME (IF DIFFERENT FROM PHYSICIAN) _____

PHONE _____ FAX _____ EMAIL _____

TREATMENT INFORMATION

CANCER TYPE _____

TREATMENT PLAN (PLEASE CHECK ALL THAT APPLY)

- ☐ SURGERY TO THE REPRODUCTIVE AREA, PLEASE EXPLAIN _____
- ☐ RADIATION TO THE BRAIN OR REPRODUCTIVE AREA, PLEASE EXPLAIN _____
- ☐ CHEMOTHERAPY, PLEASE EXPLAIN _____
- ☐ OTHER, PLEASE EXPLAIN _____

TREATMENT TIMELINE (SHOULD FALL AFTER SPERM BANKING):

ESTIMATED START DATE _____ ESTIMATED END DATE _____

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For the following two questions, please check yes or no. ANSWERS ARE REQUIRED FOR BOTH QUESTIONS; INCOMPLETE ANSWERS WILL DELAY PROCESSING.

MY INTENDED TREATMENT PLAN PRESENTS A RISK THAT THE PATIENT MAY BECOME INFERTILE.

☐ YES ☐ NO

ARE THERE ANY KNOWN MEDICAL CONTRAINDICATIONS TO THE ABOVE-NAMED PATIENT UNDERGOING FERTILITY PRESERVATION TREATMENTS AND THE ASSOCIATED RISKS AND SIDE EFFECTS?

☐ YES ☐ NO

The Lance Armstrong 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 Foundation's Fertile Hope Program.

ONCOLOGIST SIGNATURE _____ DATE _____

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