



# Grant Information & Application

## WHAT IS **BANKING ON THE FUTURE**

The **Banking on the Future** program is brought to you by **Fertility Within Reach**®—a non-profit dedicated to helping individuals increase access to fertility treatment and preservation, as well as fertility insurance benefits. **Fertility Within Reach** wants to insure that the cost of adolescent reproductive cell storage is not a major obstacle for oncology patients by providing this grant.

## WHAT IS COVERED BY THE GRANT

The **Banking on the Future** grant covers one year of reproductive cell/tissue storage, as well as cryobank administration and consultation fees, sperm collection, infectious disease testing (where applicable) and freezing.

Deeply discounted rates have been negotiated for **Banking on the Future** grant recipients for subsequent year storage, up to age 24. Please see participating cryobanks and their offerings at the end of this application.

After age 24, participating cryobanks have agreed to offer **Banking on the Future** grant recipients **LiveStrong Fertility's** discounted storage rates without submitting an additional application to **LiveStrong Fertility**.

## HOW TO FILL OUT GRANT APPLICATION

Please review all pages of this grant application and fill out all areas. An incomplete application can cause delays in the processing and awarding of grants.

This pdf application provides an opportunity to create an electronic signature. A camera on your computer is required. At the top left of the document (next to the search bar) roll over the toolbar icon which will say, "Show edit toolbar". This will provide a dropdown menu of tools, including a signature or "Sig" icon. Follow the directions to create a signature.

Patients/guardians need to fill out pages two and four of this application, while the treatment team will need to fill out page three. The treatment team can submit page three of this application directly to **Fertility Within Reach** or provide it to the patient/guardian for submission to **Fertility Within Reach**, along with pages two and four.

Completed forms should be emailed to [admin@fertilitywithinreach.org](mailto:admin@fertilitywithinreach.org). If you have any questions or need assistance, please call or email **Fertility Within Reach**.

## WHAT HAPPENS IF AWARDED GRANT

You will be notified by telephone and in writing if you are selected as a grant recipient. During that call you will receive the name and contact information for the cryobank you choose. **Fertility Within Reach** will also contact the cryobank you select so they know to expect your call. Details of the reproductive cell/tissue storage will be provided directly by the cryobank. Patients can expect to complete authorization paperwork from their chosen cryobank. The cryobank will bill **Fertility Within Reach** for the services within this agreement.

**Fertility Within Reach** is available to answer any questions you may have. Thank you for your time and interest in our grant program.





## Personal Information

Name of Patient: \_\_\_\_\_  
FIRST MIDDLE LAST

Patient's DOB: \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female  
MONTH DAY YEAR

Parent/Guardian Name: \_\_\_\_\_  
FIRST MIDDLE LAST

Home Address: \_\_\_\_\_  
STREET APARTMENT/UNIT  
\_\_\_\_\_  
CITY STATE ZIP CODE

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Number in Household: \_\_\_\_\_

Annual Household Income: \_\_\_ \$0-\$50,000 \_\_\_ \$50,000-\$100,000 \_\_\_ \$100,000-\$150,000 \_\_\_ \$150,000-\$200,000 \_\_\_ \$200,000+

Health Insurance Provider: \_\_\_\_\_

Does your insurance cover reproductive cell/tissue storage: \_\_\_\_\_

### CERTIFICATION OF PERSONAL INFORMATION

I/We, \_\_\_\_\_, swear under oath that the information provided in this application is truthful and accurate. I/We give Fertility Within Reach, Inc. permission to contact any individual and/or professional referenced in this application to verify the submitted information. I/We acknowledge receipt of the notice of privacy practices.

\_\_\_\_\_  
ELECTRONIC SIGNATURE OF APPLICANT (SIGN BELOW IF MINOR) PRINTED NAME DATE

\_\_\_\_\_  
ELECTRONIC SIGNATURE OF PARENT/GUARDIAN PRINTED NAME DATE

Please contact **Fertility Within Reach** with any questions or for application assistance.

Rev1 1.2.18

857.636.8674 • [admin@fertilitywithinreach.org](mailto:admin@fertilitywithinreach.org)



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ADVOCATING FOR FERTILITY HEALTH BENEFITS



# Verification of Medical Necessity

(to be filled out by treating physician or medial team)

## INSTRUCTION TO THE PATIENT

**Banking on the Future's** grant application must include a verification of medical necessity from your treating physician or medical team. A letter from your physician or treatment team could be used in place of this form. However the information within the letter must contain the patient's name and confirm the patient has a medical need to store their reproductive cells prior to cancer treatment.

This Verification of Medical Necessity form or a treatment letter can be emailed by the patient or medical team to **Fertility Within Reach** at [admin@fertilitywithinreach.org](mailto:admin@fertilitywithinreach.org).

## TO THE TREATING PHYSICIAN AND/OR MEDICAL TEAM

**Fertility Within Reach's Banking on the Future** program provides grants to post-pubertal pediatric oncology patients facing sterilizing cancer treatment. We appreciate the opportunity to support your patient's efforts to preserve their fertility.

Please fill out, sign and return this form to your patient or directly to **Fertility Within Reach** at [admin@fertilitywithinreach.org](mailto:admin@fertilitywithinreach.org) so we can process this grant application.

Patient Name: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

STREET

APARTMENT/UNIT

CITY

STATE

ZIP CODE

By signing this form, you are verifying that your patient is an oncology patient with a medical need to store their reproductive cells prior to cancer treatment.

\_\_\_\_\_  
ELECTRONIC SIGNATURE OF MEDICAL TEAM

\_\_\_\_\_  
DATE

Please contact **Fertility Within Reach** with any questions or for application assistance.

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## Participating Cryobanks & Services Offered

### REPROTECH LIMITED

888-489-8944

33 Fifth Avenue NW, Suite 900; St. Paul, MN 55112

**Locations:** Coconut Creek, FL; St. Paul, MN; Reno, NV; Mesquite, TX

**Type of Reproductive Cell/Tissue Storage:** sperm, egg, testicular tissue, ovarian tissue, embryo

**Collection Methods:** mail-in kit

**Discounted Subsequent Year Costs:** \$75 for sperm/egg, \$106 for embryo

### ARIZONA ANDROLOGY LABORATORY & CRYOBANK

520-855-2689

850 North Kolb Road; Tucson, Arizona 85710

**Locations:** Tucson, AZ

**Type of Reproductive Cell/Tissue Storage:** sperm

**Collection Methods:** drop off

**Discounted Subsequent Year Costs:** \$200 for sperm, testicular/ovarian tissue, \$250 for embryo

### CALIFORNIA CRYOBANK

866-927-9622

11915 La Grange Avenue; Los Angeles, California 90025

**Locations:** Palo Alto, CA; Los Angeles, CA; Houston, TX; Cambridge, MA; New York, NY

**Type of Reproductive Cell/Tissue Storage:** sperm, egg, embryo

**Collection Methods:** in-house, drop off

**Discounted Subsequent Year Costs:** \$200 for sperm, testicular/ovarian tissue, \$250 for embryo

### FAIRFAX CRYOBANK

800-338-8407

3015 Williams Drive, Ste. 110; Fairfax, Virginia 22031

**Locations:** Austin, TX; Philadelphia, PA; Roseville, MN; San Francisco, CA; Pasadena, CA

**Type of Reproductive Cell/Tissue Storage:** sperm

**Collection Methods:** in-house, mail-in kit

**Discounted Subsequent Year Costs:** \$200 for sperm, testicular/ovarian tissue, \$250 for embryo

### MAZE LABORATORIES

646-380-4000

110 East 40th Street, Ste. 704; New York, New York 10016

**Locations:** Westchester, NY and New York, NY

**Type of Reproductive Cell/Tissue Storage:** sperm

**Collection Methods:** in-house

**Discounted Subsequent Year Costs:** \$200 for sperm, testicular tissue

### NEW ENGLAND CRYOGENIC CENTER

800-991-4999

500 Donald J. Lynch Boulevard; Marlborough, Massachusetts 01752

**Locations:** Newton, MA

**Type of Reproductive Cell/Tissue Storage:** sperm, egg, embryo

**Collection Methods:** in-house, drop off

**Discounted Subsequent Year Costs:** \$200 for sperm, testicular/ovarian tissue, \$250 for embryo

### SEATTLE SPERM BANK

206-588-1484

4915 25th Avenue NE, Ste. 204; Seattle, WA 98105

**Locations:** Phoenix, AZ and Seattle, WA

**Type of Reproductive Cell/Tissue Storage:** sperm

**Collection Methods:** in-house

**Discounted Subsequent Year Costs:** \$200 for sperm, testicular/ovarian tissue, \$250 for embryo

### NOTES

**Infectious Disease Testing:** For all participating cryobank options, patients have 30 days, from day of collection, to present infectious disease testing results to the cryobank. Without results, patients could face a fee for lack of infectious disease testing.

**Additional Sperm Collection:** For those choosing additional sperm collection, a maximum of \$100 per collection is owed to the cryobank at the time of the initial collection.

Please contact **Fertility Within Reach** with any questions or for application assistance.

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## Selecting Your Cryobank & Rate Agreement

Chosen Cryobank: \_\_\_\_\_

Reproductive Cells to Store: \_\_\_\_\_

Chosen Collection Method: \_\_\_\_\_

Location: \_\_\_\_\_

### NEGOTIATED RATE AGREEMENT

As stated on the Grant Information page, this **Banking on the Future** grant covers one year of reproductive cell/tissue storage, as well as cryobank administration and consultation fees, sperm collection, infectious disease testing (where applicable) and freezing. It does not cover additional sperm collection (optional) and subsequent years of storage. By signing this, you are agreeing to these rates which are outlined on the Participating Cryobanks page.

\_\_\_\_\_  
ELECTRONIC SIGNATURE OF APPLICANT (SIGN BELOW IF MINOR)

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
ELECTRONIC SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

