Grant Information & Application: Oncology

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 ensure that the cost of adolescent reproductive cell storage is not a major obstacle for oncology patients by providing this grant.

WHO IS ELIGIBLE FOR THE GRANT

The Banking on the Future grant is available to adolescent oncology patients through the age of 21. Oncology patients who wish to preserve their fertility by storing their reproductive cells/tissue prior to medical treatments may apply for this grant as an attempt to gain financial assistance for the first year of storage and discounted rates for subsequent years.

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.

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 processing and awarding of grants.

Patients/guardians need to fill out pages 2 and 7 of this application, while the treatment team will need to fill out page 3. The treatment team can submit page 3 of this application directly to Fertility Within Reach or provide it to the patient/guardian for submission to Fertility Within Reach, along with pages 2 and 7.

Completed forms should be emailed to 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 for banking will be provided directly by the cryobank. The cryobank will bill Fertility Within Reach for the services within this agreement.

Fertility Within Reach is available to answer 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

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.

__________________________________________ DATE
SIGNATURE OF APPLICANT (SIGN BELOW IF MINOR) PRINTED NAME

__________________________________________ DATE
SIGNATURE OF PARENT/GUARDIAN PRINTED NAME

Please contact Fertility Within Reach with any questions or for application assistance.
857.636.8674 • admin@fertilitywithinreach.org
Verification of Medical Necessity
(to be filled out by treating physician or medical 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 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.

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 so we can process this grant application.

Patient Name: ____________________________

☐ This patient is an adolescent oncology patient with a medical need to store their reproductive cells prior to treatment.

Physician Name: ____________________________ Phone: ____________________________

Practice Name: ____________________________

Practice Address: ____________________________

STREET

APARTMENT/UNIT

CITY

STATE

ZIP CODE

SIGNATURE OF MEDICAL TEAM

DATE

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Participating Cryobanks & Services Offered

**REPROTECH LIMITED**
888-489-8444
33 Fifth Avenue NW, Suite 900; St. Paul, MN 55112
**Locations:** Coconut Creek, FL; St. Paul, MN; Reno, NV; Garland, 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/OT/TT, $106 for embryo

**LEGACY**
617-514-0901
**Locations:** Nationwide (at-home service)
**Type of Reproductive Cell/Tissue Storage:** sperm
**Collection Methods:** mail-in kit
**Discounted Subsequent Year Costs:** $115/year for storage

**ARIZONA ANDROLOGY LABORATORY & CRYOBANK**
520-855-2689
850 North Kolb Road, Tucson, AZ 85710
**Locations:** Tucson, AZ
**Type of Reproductive Cell/Tissue Storage:** sperm
**Collection Methods:** mail-in kit
**Discounted Subsequent Year Costs:** $200 for sperm, testicular/ovarian tissue, $250 for embryo

**BOSTON IVF**
888-300-3483
130 2nd Ave, Waltham, MA 02451
**Locations:** Waltham, MA
**Type of Reproductive Cell/Tissue Storage:** sperm, eggs, embryos
**Collection Methods:** off-site, mail in through Legacy
**Discounted Subsequent Year Costs:** $200 for sperm, egg, $250 for embryo

**CALIFORNIA CRYOBANK**
866-477-3762
11915 La Grange Avenue, Los Angeles, CA 90025
**Locations:** Palo Alto, CA; Los Angeles, CA; 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

**CCRM FERTILITY**
877-201-6931
9380 Station Street, Suite 425, Lone Tree, CO 80124
**Locations:** Atlanta, GA; Marietta, GA; Chestnut Hill, MA; Denver, CO; Lone Tree, CO; Louisville, CO; Frisco, TX; Houston, TX; Edina, MN; New York, NY; Vienna, VA; Menlo Park, CA
**Type of Reproductive Cell/Tissue Storage:** sperm, egg, embryo
**Collection Methods:** in-house
**Discounted Subsequent Year Costs:** $200 for sperm, egg, $250 for embryo

**CRYOBANK AMERICA**
817-945-8708
3050 S. Center St. Suite 100, Arlington TX 76014
**Locations:** Arlington, TX
**Type of Reproductive Cell/Tissue Storage:** sperm
**Collection Methods:** in-house, mail-in kit, drop off
**Discounted Subsequent Year Costs:** $200 enrollment and collection, $100 each additional collection, $16.66/mo storage; additional fees for bloodwork

**FAIRFAX CRYOBANK**
800-338-8407
3015 Williams Drive, Ste. 110, Fairfax, VA 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
633 3rd Ave 9th Floor, New York, NY 10017
**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

**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.

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Selecting Your Cryobank & Rate Agreement

After reviewing all storage options and identifying which of the scenarios you choose, please sign below.

Chosen Cryobank: ____________________________________________________________

Reproductive Cells to Store: __________________________________________________

Chosen Collection Method: _____________________________________________________

Location: ___________________________________________________________________

NEOTIATED RATE AGREEMENT

As stated on the Grant Information page, this Banking on the Future grant covers one year of reproductive cell/tissue storage. It does not cover additional sperm collection (optional) and subsequent years of storage. By signing this, you are agreeing additional rates which are outlined on the Participating Cryobank page.

________________________________________  _________________________________  __________
SIGNATURE OF APPLICANT (SIGN BELOW IF MINOR)     PRINTED NAME                 DATE

________________________________________  _________________________________  __________
SIGNATURE OF PARENT/GUARDIAN                 PRINTED NAME                 DATE

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