Verna's Purse Financial Assistance Criteria & Application Oocyte/Ovarian Tissue/Semen/Testicular Tissue

PROGRAM OVERVIEW

The Verna's Purse Financial Assistance program is designed to provide discounted long-term storage for clients with oocytes/semen/ovarian tissue/testicular tissue already in storage (whether already at ReproTech or in the process of transferring to ReproTech for long-term storage) facing financial hardship. ReproTech and its network of Freezing Centers participate in LIVESTRONG's Fertility Discount Program to provide services to patients who have yet to bank.

What is covered?

Discounts are for annual storage services and shipping of specimens from another facility to ReproTech for long-term storage. Approved applicants will receive a 70% discount off the regularly priced annual storage fee for three years. Shipping fees are also discounted.

Current fees as of 1/1/24*

	Regular Price	Verna's Purse Discounted Price
Annual Standard Storage	$370	$111
Annual Potentially Infectious Storage	$555	$166.50
Shipping - per shipping tank	$375	$150

*Storage and shipping fees are subject to change. Discounted fees are based on the current fees at the time of annual invoicing or shipment. View reprotech.com/fee-schedule or call us to verify current fees.

What is not covered?

Prior to shipping oocytes/semen/ovarian tissue/testicular tissue to ReproTech, all patients are required to have infectious disease blood testing. If the test results are not received or if the test results indicate a potentially infectious disease, the participant may be charged additional quarantine fees.

HOW TO APPLY

Eligibility Criteria

ReproTech selects participants for the Financial Assistance program based on the following criteria.
Only participants who meet ALL of the following criteria will be accepted.

- US Citizen or Permanent Resident
- Annual household income (Adjusted Gross Income) less than $75,000 (single) or $100,000 (married)
- Diagnosis of cancer
- Prescribed treatments present the risk of infertility as determined by an oncologist or Reproductive Endocrinologist
- No contradiction to fertility preservation and/or fertility treatments as determined by both an oncologist and reproductive endocrinologist

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 ReproTech via email or fax to:

ReproTech Connecticut
infoCT@reprotech.com
Fax: 203-497-3455

ReproTech Florida
infoFL@reprotech.com
Fax: 954-570-7693

ReproTech Minnesota
infoMN@reprotech.com
Fax: 651-489-0442

ReproTech Nevada
infoNV@reprotech.com
Fax: 775-284-2799

ReproTech Texas
infoTX@reprotech.com
Fax: 469-547-2408

Please note your application will not be processed if you do not meet the above criteria or if any of the following information has not been received:

- Completed Patient Authorization and Consent Form
- **Copy of your Federal Tax Returns from the most recent year (IRS Form 1040)**
  If you did not file taxes, call the IRS at (800) 829-1040 and request a Tax Return Transcript.

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Next Steps

Upon receipt and review of your application, ReproTech will notify you of your approval or denial by phone or email. Please allow 1 to 2 weeks for a response. All approved applicants will be given additional information in writing regarding next steps.

Please note prior to receipt of your specimens at ReproTech, you are required to have infectious disease tests. If your specimens are not currently at ReproTech, contact your current oocyte/semen/ovarian tissue/testicular tissue bank to find out which blood tests you have completed and forward those to ReproTech. If you have not completed the required tests, you may want to have these tests conducted by your oncologist while your application is being processed.

PATIENT AUTHORIZATION & CONSENT FORM

Please complete ALL the fields in the following form and keep a copy for your records. Incomplete applications cannot be processed.

Patient's Personal Information

Last Name________________________________ First____________________ Middle__________________

Parent/Guardian Name (if patient is a minor) ____

Street Address____

City_____________________________________ State___________________ ZIP Code________

Cell Phone________________________________ Home Phone _____________________ Email ___________________________

Social Security____________________________ Date of Birth_____________________ Sex/Gender______________

Cryobank or clinic where you plan to or have bank(ed) your oocytes, semen, ovarian tissue, or testicular tissue:

Cryobank/clinic: ____ Contact: ______________________

Financial Information

Average Three-Year Annual Household Income **(Adjusted Gross Income)** ____________________________

Please write your average three-year annual household income (add last three years of income and divide by 3) and include your federal tax returns from the most recent year (Form 1040). If patient is under 18, please provide federal tax returns for the patient's parents or legal guardians.

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 ReproTech, its representatives and/or agents in order to assess my eligibility for participation in the "Financial Assistance" Program.

I authorize ReproTech, its representatives and agents to request and obtain from my physicians and any insurer medical and other patient information related to my treatment for cancer and infertility. I agree to immediately inform ReproTech if my income or insurance status changes and to provide any documentation that ReproTech requests to verify the same. I further authorize these parties to contact me directly, if necessary, to process this application.

Verna’s Purse Financial Assistance
Criteria & Application
Oocyte/Ovarian Tissue/Semen/Testicular Tissue

I understand that application for assistance from the “Financial Assistance” Program does not guarantee that assistance will be provided. I understand eligibility for the “Financial Assistance” Program is subject to approval under the criteria and requirements set forth herein and that ReproTech 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 the “Financial Assistance” Program and to notify ReproTech if aspects of my certification and authorization form are no longer applicable.

I acknowledge that I need to submit my 1040 Federal Tax Return or proof of non-filing as outlined above to have my application for financial assistance reviewed for approval. I agree to submit this form via fax, email, or mail.

I understand that ReproTech is not itself a medical provider, and by submitting this application with my signature below, I acknowledge and agree that ReproTech 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 ReproTech 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 ReproTech 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 the “Financial Assistance” program except for claims resulting wholly from the gross negligence of ReproTech.

I have discussed with my physicians the risks, side effects and other aspects of oocyte/semen/ovarian tissue/testicular tissue 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 healthcare providers, including but not limited to any oncologist.

I understand that the agreements under the “Financial Assistance” Program shall be construed and interpreted in accordance with the laws of the State of Delaware without regard to its conflicts of law provisions.

Patient Signature (or Parent/Guardian if minor) ____ Date ____________________

Call your ReproTech Storage Location with any questions:

ReproTech Connecticut
203-816-5598

ReproTech Florida
954-570-7687

ReproTech Minnesota
651-489-0827

ReproTech Nevada
775-284-2795

ReproTech Texas
469-547-2399