

Pittsburgh Cryo-Trust Financial Assistance for Cancer Patients and Survivors Criteria and Application - Oocyte/Ovarian Tissue/Semen/Testicular Tissue

PROGRAM OVERVIEW

Pittsburgh Cryo-Trust's Financial Assistance program is designed to provide discounted long-term storage for clients with oocytes/semen/ovarian tissue/testicular tissue already in storage (either at Pittsburgh Cryo-Trust or at UPMC/other facilities) facing financial hardship.

What is covered?

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

Current fees as of 4/1/24*

| | Regular Price | Cryo-Trust's Discounted Price |
|-------------------------|---------------|-------------------------------|
| Annual Standard Storage | \$462 | \$138.60 |

*Storage fees are subject to change. Discounted fees are based on the current fees at the time of annual invoicing. View cryo-trust.com/fees or call us to verify current fees.

What is not covered?

Prior to transferring oocytes/semen/ovarian tissue/testicular tissue to Pittsburgh Cryo-Trust, all patients are required to have infectious disease blood testing.

HOW TO APPLY

Eligibility Criteria

Pittsburgh Cryo-Trust 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 Pittsburgh Cryo-Trust via email to:

info@cryo-trust.com

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, Pittsburgh Cryo-Trust 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 Pittsburgh Cryo-Trust, you are required to have infectious disease tests. If your specimens are not currently at Pittsburgh Cryo-Trust, contact your current oocyte/semen/ovarian tissue/testicular tissue bank to find out which blood tests you have completed and forward those to Pittsburgh Cryo-Trust. 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.



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

I authorize Pittsburgh Cryo-Trust, 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 Pittsburgh Cryo-Trust if my income or insurance status changes and to provide any documentation that Pittsburgh Cryo-Trust requests to verify the same. I further authorize these parties to contact me directly, if necessary, to process this application.

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 Pittsburgh Cryo-Trust 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 Pittsburgh Cryo-Trust 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 Pittsburgh Cryo-Trust is not itself a medical provider, and by submitting this application with my signature below, I acknowledge and agree that Pittsburgh Cryo-Trust 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 Pittsburgh Cryo-Trust 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 Pittsburgh Cryo-Trust 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 Pittsburgh Cryo-Trust.

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 Pittsburgh Cryo-Trust with any questions:

412-664-5497