Team Maggie's Dream

Providing support, education and financial assistance for young adults with Cancer seeking fertility preservation options

Grant Application

Please fill in ALL fields of this form and attach sufficient documentation of financial need (tax return/W-2). Only completed applications will be processed. Please print out completed application and mail to address below

Applicant/Patient Information

Last Name First Middle

Street Address City State Zip Code

County of Residence ☐ US Citizen yes ☐ no Date of Birth / /

Phone Fax Email

Marital Status ☐ Sex Male ☐ Female Do you have Children? Annual ***Household*** Income/

Insurance Carrier Group Number Policy Number

Telephone Number Uninsured for Application Fertility Services ☐ yes

☐ Included - A personal note about why this grant is important to you and include financial need**.**

☐ If afforded a grant the way for this program to continue is through a commitment on my part to pay it forward to help the next recipient. Example – Birthday fundraiser on Facebook

Medical Information

Type of Cancer Diagnosed

Type of Treatment

Date of Treatment

Oncologist Name

Oncologist Address and Telephone Number

Fertility Services

Check all that apply

☐ Step 1 – Oocyte *Oocyte Retrieval/Cryopreservation* ☐ Sperm Banking

☐ Step 1 – Embryo *Oocyte Retrieval and Embryo Culture/Cryopreservation*

☐ Storage Fees for one (1) calendar year (applies to oocyte, embryo and sperm)

I certify that all of 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 Team Maggie for a Cure, Inc.,, its representatives and/or agents in order to assess my eligibility for participation in the Grant Program. I authorize Team Maggie, 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 Team Maggie if any of the information provided in this application changes and is no longer accurate and to provide any documentation that Team Maggie requests to verify accuracy. I further authorize Team Maggie, its representatives and agents to contact me directly, if necessary, to process this application. I understand that application for assistance from the Team Maggie, Inc., does not guarantee that assistance will be provided. I understand eligibility for the Team Maggie Grant is subject to approval under the criteria and requirements set forth herein and that Team Maggie reserves the right to change or terminate the Team Maggie Grant Program without prior notice. I understand that Team Maggie's role is limited to providing financial assistance directly to selected recipients. I understand that Team Maggie is not a medical provider of any sort and is not liable in any way for any aspect of my treatment.

Patient Signature Date

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Oncologist Referral and Certification Form

Please fill in ALL fields of this form. Only completed applications will be processed. Please print out completed application and mail to address below for processing.

Patient Information

Last Name First Middle

Street Address City State Zip Code

Phone Fax Email

Physician Information

Last Name First Middle

Title State License Number Clinic or Hospital

Street Address City State Zip Code

Phone Fax Email

Treatment Information

Cancer Type:_____

Stage:_____

Grade:_____

Current Treatment Plan:

- ☐ Surgery, Please explain_____
- ☐ Radiation, Please explain_____
- ☐ Chemotherapy, Agents & Dose_____
- ☐ Other, Please explain_____

Current Treatment timeline: Start Date: End Date:

Please check yes or no; incomplete answers will delay processing

My intended treatment plan presents a risk that the patient may become infertile.

☐ Yes ☐ No

TeamMaggieForACure.org
227 Hillcrest Dr. Roswell, GA 30075
Phone: 678-977-5755 Email: teammaggieforacure@gmail.com

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Prior Treatments:

- ☐ Surgery, location and procedure _____
- ☐ Radiation, location and total dose _____
- ☐ Chemotherapy, agents and total dose_____
- ☐ Other, Please explain_____

Prior Treatment timeline: Start Date: End Date:

Oncologist Signature Date

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Reproductive Endocrinology or Urologist Certification Form

Please fill in ALL fields of this form. Only completed applications will be processed. Please print out completed application and mail to address below for processing.

Patient Information

Last Name First Middle

Street Address City State Zip Code

Phone Fax Email

Cancer Type

Physician Information

Last Name First Middle

State License Number Certification Affiliation

Street Address City State Zip Code

Phone Fax Email

Billing Contact Information

Name Email Phone

Treatment Plan

☐ Embryo Freezing ☐ Egg Freezing ☐ Sperm Banking

☐ Step One ☐ Step One

☐ Cycle One ☐ Cycle Two

Ovarian Reserve Testing _Pending/Unavailable _Circle one for Day 3 or Random hormone testing.

Day 3/Random FSH _____ Day 3/Random E2 _____ AMH _____ Antral Follicle Count _____

Semen Analysis Testing: Volume_____ Concentration _____ Motility_____

Previous Fertility Preservation Treatment – if any

Reproductive Endocrinologist Signature Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Participant name_____

Name of the Covered Entity (Oncologist) authorized to provide the information_____
Name of the Covered Entity (Insurance Carrier) authorized to provide the Information_____
Name of the Covered Entity (Reproductive Endocrinology) authorized to provide Information_____

Persons/organizations authorized to receive the information **Team Maggie For A Cure, Inc.**

Description of information to be used or disclosed (including date(s)_____

Specific purpose of the disclosure *(Note: If this authorization is being made at your request, you may state "This is done at my request" and leave the rest blank unless you choose to state a purpose.)*

_____

This authorization will expire one year from the date next to my or my personal representative's signature below, or earlier upon the occurrence of the following event (must relate to the purpose of the authorization).

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

• I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, **but I understand that the revocation will not effect any actions the entity took before I revoke my authorization.**
• I may see and copy the information described on this form if I ask for it.
• I am not required to sign this form to receive health care benefits to which I am otherwise entitled.
• The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity and I understand that the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA).

III. Signature of Participant or Participant's Representative

_____

Signature of participant or representative Date
(Form MUST be completed before signing)

Printed name of the participant:_____
Printed name of the participant's personal representative:_____
Relationship to the participant, including authority for status as representative:_____

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

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CONSENT AND RELEASE AGREEMENT
REGARDING PHOTOS / VIDEOS / AUDIO RECORDINGS/WRITTEN MATERIALS

In consideration of my participation in the programs and activities provided by ***Team Maggie for a Cure, Inc.*** (**"*Organization*"**), I hereby agree as follows:

1. Copyrights and Usage. I hereby grant to ***Organization*** the right and permission, in respect of any photographs, videos and/or audio recordings, which any of its members, officers, directors, employees, contractors, volunteers, representatives, successors and assigns may take or have taken of me or which I have provided to Organization, or in which I may be included with others, or written statements, testimonials, personal stories or other media that I have submitted to Organization, to copyright the same in the name of ***Organization*** or otherwise; to use, reuse, publish and re-publish the same, in whole or in part, in conjunction with any printed matter in any and all media now or hereafter known, including web pages, electronic mails and the like, for illustration, art, promotion, advertising, fundraising or any other purpose; and to use my own or a fictitious name, my likeness and any statement made by me in connection therewith if ***Organization*** so chooses, without payment or any other consideration.

2. Ownership, Modification and Publication. I understand and agree that any such photographs, videos and audio recordings, including without limitation all negatives, prints and digital reproductions thereof, written statements, testimonials, personal stories or other media shall be and will become the property of ***Organization***. I hereby irrevocably authorize ***Organization*** to edit, alter, digitally compose, copy, exhibit, publish or distribute any such photographs, videos and audio recordings, written statements, testimonials, personal stories or other media for purposes of publicizing ***Organization***'s programs and activities or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product or products or the advertising copy or printed matter, whether written or electronic, of any such material in which my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use or publication of any such photographs, videos and audio recordings.

3. Release and Hold Harmless. I release, discharge, and agree to hold harmless and defend ***Organization*** and any and all of its members, officers, directors, employees, contractors, volunteers, representatives, successors and assigns from any liability by virtue of any reason in connection with the making and use of any such photographs, video and audio recordings, written statements, testimonials, personal stories or other media, including blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the making of said photographs, video and audio recordings or in any subsequent processing thereof, as well as any publication of them, including without limitation any claims for libel or violation of any right of publicity or privacy.

4. Severability. In the event that any portion of this agreement is held to be invalid or unenforceable, the validity or enforceability of the remainder of this agreement shall be unaffected and shall remain valid and enforceable to the full extent permissible under law.

5. Governing Law. This agreement and any disputes arising under or in connection with it shall be governed by the laws of the State of Georgia. I hereby submit to the exclusive jurisdiction of the state and federal courts of the State of Georgia for the settlement of any and all such disputes.

6. Consent. I am over eighteen (18) years of age (nineteen (19) in Alabama and Nebraska; twenty-one (21) in Mississippi and Puerto Rico) and I have full legal capacity to grant this consent and release, and have read and understood the above consent and release prior to its execution. If I am under eighteen (18) (nineteen (19) in Alabama and Nebraska; twenty-one (21) in Mississippi and Puerto Rico) years of age, my parent or guardian attests that he or she has read and understands the above consent and release prior to execution, and agrees to such consent and release. This release is made on behalf of myself, my heirs, executors, administrators and assigns.

DATED THIS _____DAY OF_____YEAR_____

SIGNATURE _____

PRINTED NAME _____

Address _____

_____

(The following consent must be signed, if the person signing above is under 18 years of age, (nineteen (19) in Alabama and Nebraska; twenty-one (21) in Mississippi and Puerto Rico))

I, the undersigned, being the parent or guardian of the above person, do hereby consent to the above consent and release.

PARENT/GUARDIAN
SIGNATURE_____