Caporal Assistance Network
Providing Hope To Young Adults Living With Cancer

Mariposa Program Application
GENERAL INFORMATION

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

Applicant/Patient Information

Last Name | First | Middle

Street Address | City | State | ZIP Code

County of Residence | U.S. Citizen ◉ Yes ○ No | Date of Birth / /

Phone ( ) | Fax ( ) | Email

Marital Status | Sex ○ Male ○ Female | Annual Household Income

Insurance Carrier | Group Number | Policy Number

Telephone Number | Uninsured for Applicable Fertility Services ☐

Medical Information

Type of Cancer Diagnosed

Type of Treatment

Date of Treatment

Oncologist Name

Oncologist Address & Telephone Number

Fertility Services

Check All That Apply

- ☐ Step 1 - Oocyte *Oocyte Retrieval/Cryopreservation (up to $1500)*
- ☐ Step 2 - Oocyte *Oocyte Thaw/Insemination and Embryo Culture/Transfer (up to $1500)*
- ☐ Step 1 - Embryo *Oocyte Retrieval and Embryo Culture/Cryopreservation (up to $2000)*
- ☐ Step 2 - Embryo *Frozen Embryo Transfer (up to $1000)*
- ☐ Storage Fees for one (1) calendar year (applies to oocyte, embryos, and sperm)
- ☐ Sperm Banking

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

Patient Signature SIGN HERE Date

Contact: Caporal Assistance Network, Attn: Mariposa Program P.O. Box 90963 Austin, TX 78709-0963
e. info@caporalassistance.org t. (512) 535-4349

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Mariposa Program Application

ONCOLOGIST REFERRAL AND CERTIFICATION FORM

Please fill in ALL fields of this form. Only complete 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 Name

Street Address | City | State | ZIP Code

Phone ( ) | Fax ( ) | Email

Treatment Information

Cancer Type

Treatment plan (Please check all that apply)

- ☐ Surgery to the reproductive area, please explain:
- ☐ Radiation to the brain or reproductive area, please explain:
- ☐ Chemotherapy, please explain:
- ☐ Other, please explain:

Treatment time line: 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

Oncologist Signature | SIGN HERE | Date

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Mariposa Program Application
REPRODUCTIVE ENDOCRINOLOGY CERTIFICATION FORM

Please fill in ALL fields of this form. Only complete 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 Name | Middle

State License Number | Certification Affiliation

Street Address | City | State | ZIP Code

Phone ( ) | Fax ( ) | Email

Treatment Plan

- ☐ Embryo Freezing
  - ☐ Step One
  - ☐ Step Two
- ☐ Egg Freezing
  - ☐ Step One
  - ☐ Step Two
- ☐ Sperm Banking

Reproductive Endocronologist Signature 

Date

Contact: Caporal Assistance Network, Attn: Mariposa Program P.O. Box 90963 Austin, TX 78709-0963
e. info@caporalassistance.org t. (512) 535-4349

Caporal Assistance Network

Providing Hope To Young Adults Living With Cancer

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: _____ ID Number: _____

Name of the Covered Entity authorized to provide the information: _____

Persons/organizations authorized to receive the information: _____

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.):* _____

_____

If a health plan or provider is requesting to receive the information described on this form, will that plan or provider receive financial or in-kind compensation in exchange for using or disclosing the health information described?

No _____ Yes (describe) _____

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

SIGN HERE

_____ _____

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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