Financial Aid Policy 2023

The Cayman Islands Cancer Society provides Financial Assistance to Cancer patients

- Who have resided in the Cayman Islands for an uninterrupted period of 24 months (or more)
- Who are legal residents and can provide proof of their residency.
- Who have little, or no, funding available to cover the costs related to their cancer care or basic daily living needs.

Financial Aid is provided on an individual basis after a completed Financial Aid Application has been submitted to CICS, along with all relevant diagnoses, release of information, insurance details, estimates and any other information that may be required outside of the information noted on the application form. The request made, along with the application, will then be provided to The Financial Aid Committee (FAC) who is responsible for determining whether aid can be provided. The FAC consists of 4-6 members who have been chosen by the Board of Directors, and will receive applications anonymously, consider each case on an individual basis, and respond to the request made within 3 working days.

Financial Aid could cover for the following instances:

- Proven Treatment Protocols.
- Outpatient Diagnostic Testing (e.g., X-ray, MRI, Blood Tests, Scans).
- Laboratory and Pathological Services.
- Lodging and Airfare for Patient and One Supporter during treatment.
- Prescribed Medications.
- Other items necessary for basic daily living needs as determined by the FA.

Financial Aid does not cover the following instances:

- Expenses incurred 30+days prior to submitting a complete application form for Financial Aid.
- Alternative treatments or therapies, and unproven, experimental, treatment Protocols.
- Applications received posthumously.
- Funeral Expenses.
- Travel related expenses not specifically mentioned including but not limited to food and car rental

The Cayman Islands Cancer Society will not endeavor to provide any Financial Aid Applicants or any relatives with medical opinions, alternative treatment locations or advice on their treatment options.

All applications are reviewed on a case-by-case basis. The granting of assistance in all cases is at the sole discretion of the Financial Aid Committee.
Failing to disclose any relevant information, providing false information or failing to advise of any change in financial circumstance after assistance has been provided may result in assistance being stopped immediately and further assistance being denied. In these cases, CICS may request that any financial assistance provided be re-imbursed within 10 days following a written request. Assistance may stop at any time at the absolute discretion of CICS.
Any assistance will stop immediately upon the death of the patient.

2023 Financial Aid Policy – Cayman Islands Cancer Society.
114 Maple Road, George Town. P. O. Box 10565, Grand Cayman KY1-1005, Cayman Islands
TEL. 345-949-7618 F. 345-949-8694 Email: info@cics.ky Website: www.cics.ky

The Cayman Islands Cancer Society provides financial assistance to qualified patients, who have been diagnosed with cancer - and assistance to their families. For us to access your eligibility, there are a series of forms that we need you to complete. You will also be required to provide supporting documents.

1. CICS Financial Assistance Application Form
Enclosed is a copy of our application form for financial assistance. In order to expedite the processing of your application we ask that it be completed in its entirety at the time of submission – including the section in page 11 requesting that information on any other organization that may be providing or is considering the provision of financial aid.

2. Diagnosis
In making our decision, it is necessary for a written diagnosis from your doctor to accompany your completed application. The appropriate form for your doctor to complete is attached (page 12).

3. Release of Information
It may be necessary for CICS to obtain information from your health insurance provider or from other individuals; we therefore ask that you also complete the form in page 11 authorizing them to release information on your condition to the Cancer Society.

4. Assistance with Outstanding Bills/Estimates
If you are requesting assistance with existing medical bills or other expenses associated with your illness, please attach copies of these bills to your application.
If you are seeking assistance with upcoming treatment and associated expenses, you must attach a quotation for the anticipated costs you will incur.

5. Health Insurance Coverage
We will require that you provide CICS with a letter from your health insurance company stating what portion of your bills are not covered.

6. Other Relevant Information
You may also include any other information that you feel is relevant.

Once your application and documents are received in full, it will be forwarded to the Financial Aid Committee who will make every effort to render a decision within (3) three working days upon receipt of your request. Should you require additional information or wish to check on your application, please call us at 949-7618 or email info@cics.ky

Yours Sincerely,
Team CICS.

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The Cayman Islands Cancer Registry is a collaborative effort between the Cayman Islands Cancer Society and the Health Services Authority.

All information collected is kept strictly confidential and is used for statistical purposes only.

When cancer survivors provide us with this basic information about their diagnosis, we get a clearer picture of how this disease impacts the community. Once we understand cancer trends in our population, we can do more to develop cancer and prevention strategies. Registering is fast and easy.

Please confirm:

- Can the CICS staff have the Cancer Registrar contact you directly about registering?

Name: _____

Phone: _____

Email: _____

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CAYMAN ISLANDS CANCER SOCIETY

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YOUR APPLICATION FOR FINANCIAL ASSISTANCE

Please answer all questions.
If you need additional space to answer any question, please use the space provided in the **Additional Information** (page 10).

Date: _____

Client Information

Client's (Patient) Name: _____
Surname First Name Middle Initial

Supporter's Name (Page 9): _____
Surname First Name Middle Initial

Other Name/Names you are known by: _____

Gender (circle appropriate answer): Male / Female

Date of Birth (DD/MM/YYYY): Age: _____

Home Phone: _____ Work Phone: _____ Cell Phone: Fax: _____

Email: _____

Mailing Address: P.O. Box _____ Island: _____ Postal code: _____

Home Address: House #: _____ Street: _____

District: _____

Directions to your Home Address: _____

_____

Do you own or rent the property where you live? (Circle appropriate answer) OWN / RENT

If renting – what is the lease period? _____

Marital Status (Circle appropriate answer) Single Married Divorced Separated Widowed

Immigration Status:

☐ Caymanian ☐ Residency and Employment Rights Certificate Holder

☐ Permanent Resident ☐ Work Permit Holder

If not Caymanian – years of Residency in the Cayman Islands: _____

Do you have a disability? (Circle appropriate answer): YES / NO

If you do, please share what your disability is? _____

_____

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Are you employed? (Circle appropriate answer): YES / NO

Name of Employer and position: _____
Your supervisor's Name: _____
Your work address: _____
Phone Number: _____

If you are un-employed: please state, the reason(s) for unemployment:
_____
_____

Insurance Information

Do you have medical insurance (circle appropriate answer): YES / NO
If NO state reason: _____
If YES – Name of Company:
Policy ID: _____Employee Number: _____
Address: _____ Phone Number: _____
Email address: _____
Contact Person: _____
What Does Your Insurance Not Cover? _____

Medical Information

Referral Source: _____

Name of your Doctor (in Cayman): _____

Doctor's Location: _____Phone Number: _____

Date of last visit: _____Date of next visit: _____

Name of other Doctors treating you (including overseas): _____

_____

Doctor's location: _____Phone Number: _____

Date of last visit: _____Date of next visit: _____

Diagnosis: _____

_____

When were you diagnosed with cancer? _____

What treatments have you received to date (please include surgeries and list dates): _____

_____

Date and details of next scheduled treatment: _____

_____

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Other Agencies that provide Financial Support

NAU - Needs Assessment Unit:

Are you seeing a Social Worker/Needs Assessment Unit Case Worker? (Circle appropriate answer) YES / NO
If YES, what is your social worker/Needs Assessment Unit Case Worker's name:

_____

Email Address: _____

Address: _____Phone Number: _____

How long have you been working with NAU's Case Worker? _____ (# days/weeks/Months)

OTHER:

Have you requested financial assistance from other organizations or fund raisers such as GoFundMe or local fundraisers (circle appropriate answer): YES / NO

If you answered YES, please list the organization's name, contact person and phone number below:

_____

_____

_____

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Financial Information:

Address: _____Phone Number: _____
Balance in all Accounts: CI$_____ US$ _____ Other: _____
List any assets owned such as property, land, businesses:
_____

Your monthly Income:

Employment	CI$ _____ per month
Spouse/Partner's Employment	CI$ _____ per month
Social Services	CI$ _____ per month
Child Maintenance	CI$ _____ per month
Relatives & Friends	CI$ _____ per month
Pension (including Seamen)	CI$ _____ per month
Other: _____	CI$ _____ per month

Fundraisers or financial support you receive, such as: GoFundMe page, Charity Walk on your name, Donation Cans, (Other organizations or service clubs)

TOTAL INCOME **CI$ _____ per month**

Your monthly Expenses:

Rent/Mortgage	CI$ _____ per month	Bank Loan	CI$ _____ per month
Car gas/Transportation	CI$ _____ per month	Pension	CI$ _____ per month
Credit Cards	CI$ _____ per month	Water	CI$ _____ per month
Electricity	CI$ _____ per month	Cable TV	CI$ _____ per month
Telephone	CI$ _____ per month	Internet/WIFI	CI$ _____ per month
Domestic Helper	CI$ _____ per month	Caregiver	CI$ _____ per month
Groceries	CI$ _____ per month	Other Meals	CI$ _____ Per month
Cigarettes	CI$ _____ per month	Alcoholic Beverages	CI$ _____ per month
School Fees	CI$ _____ per month	Life Insurance	CI$ _____ per month
Health Insurance	CI$ _____ per month	Car Insurance	CI$ _____ per month
Child Maintenance	CI$ _____ per month	Propane Gas	CI$ _____ per month
Miscellaneous	CI$ _____ per month	Other (please list)	CI$ _____ per month

TOTAL EXPENSES **CI$_____ per month**
SURPLUS/ (DEFICIT) **CI$ _____ per month**

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Family Information of Client:

Supporter's Name: _____

Surname First Name Middle Initial

Relation to You: _____

Mailing Address (if different from the Patient's address):

Applicant's Name (if different from the Client): _____

Surname First Name Middle Initial

Relationship to client: _____ (immediate family only)

Household Members/relation to the patient	Full Name	Date of Birth (DD/MM/YYYY)	Age	Nationality & Immigration Status.	Occupation

Spouse/Partner - Employment Information (if applicable):

Name of Employer: _____

Job title or Position: _____

Address: _____ Phone Number: _____

Email Address: _____

If unemployed, please state the reason(s) for unemployment:

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Additional Information

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Authorization for Release of Information

I do hereby authorize all Doctors, Hospitals, Financial Institutions, Insurance Companies, Department of Children & Family Services and any other organization that may be assisting me with my medical expenses to release to the Cayman Islands Cancer society, or it's duly authorized representative(s), every information deemed necessary to complete the assessment of my application for Financial Assistance including but not limited to:

- □ Medical History.
- □ Medical Billing.
- □ Medical Costs.
- □ Insurance Coverage.
- □ Terms of employment (limited to renumeration, sick pay, insurance coverage).
- □ Bank Balances.
- □ Assistance being provided.

Client's Name: _____ Date of Birth (dd/mm/yy): _____

Other Names (That you are known by): _____

Mailing Address: _____

Telephone Numbers:

Home: _____ Work: _____ Cell: _____

E-mail: _____

Witness' Name (please print) _____

Witness' Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Please provide following information if known to you:

Health Insurance Provider: _____

Group Policy #: _____ Individual Policy #: _____

Medical Record Number (if available): _____

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To Whom It May Concern Date: _____

Re: _____
Attached is an Authorization for Release of Information from the above name patient who is requesting financial assistance from CICS for their medical bills.

1. Primary Cancer: _____
2. Date of Diagnosis: _____ 3. Stage of Cancer: _____
4. Please confirm if this is ☐ A new diagnosis or ☐ A recurrence
5. Additional Diagnosis Information: _____

_____

6. Prognosis: _____
7. Is the patient currently receiving treatment? ☐ YES ☐ NO
8. If NO, please go to question 10. If YES, please see circle all that apply:

Surgery / Chemotherapy / Radiation / Clinical trial / Hormonal / Palliative Care / Other (please specify): _____

_____

9. Other information regarding treatment: _____

_____

10. If NO, is Post Treatment follow-up needed? ☐ YES ☐ NO

If YES please explain: _____

_____

_____

11. Other relevant information: _____

_____

Physician's Signature: _____ Date: _____

Physician's Name: _____

Institution: _____

Address: _____

Phone: _____ FAX: _____

Email: _____

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Checklist of required documents

The patient must provide copies of all the following:

Client's personal Information:

- ☐ Personal Identification such as a valid passport or a valid driver's license
- ☐ Health Insurance coverage letter along with a copy of the health insurance card
- ☐ Immigration documents (either a copy of your work permit, Permanent Residency Certificate, Residency and Employment rights Certificate or Caymanian Status documents)
- ☐ Proof of residential address (Utility bills, or if renting, a letter from your landlord)
- ☐ Proof of postal address, if applies
- ☐ Proof of Needs Assessment Unit assistance or any other social services assistance
- ☐ Proof of assistance sought from any other non-profit organizations, groups or associations

Client's medical Information:

- ☐ Written diagnosis from your doctor
- ☐ Medical Bills
- ☐ Quotes for treatment
- ☐ Airfare quotes
- ☐ Accommodations costs
- ☐ Medical itinerary
- ☐ Treatments received

Financial Information (documents required from both, the Patient and from the Supporter):

- ☐ Salary and income information. This should include documentation of your salary from employment contract plus any additional income from other sources such as earnings from renting out a property, running a personal business, child support if applies, etc.
- ☐ Bank Statements – a mini statement printed off the ATM from your bank institution is acceptable
- ☐ Information relating to any assets owned such as property, land or businesses.
- ☐ A copy of your lease or any other information on the property you rent
- ☐ Support received from child maintenance
- ☐ Pension deductibles or pension benefit
- ☐ School fees
- ☐ Assistance from family or friends received
- ☐ Information on any loan
- ☐ Information on Credit Card expenditure
- ☐ Spent on fuel
- ☐ Car payments

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- ☐ Car Insurance payments
- ☐ Mortgage information
- ☐ Water Bills – past 3 months
- ☐ Electricity bills- past 3 months
- ☐ Television bills
- ☐ Telephone bills – landline and/or cell phones
- ☐ Internet bills
- ☐ Domestic Helper salary, if applicable
- ☐ Caregiver salary, if applicable
- ☐ Groceries
- ☐ Other meals – Restaurants, Fast Food, diners
- ☐ Life Insurance payments
- ☐ Child Maintenance, if applicable
- ☐ Spent on purchase of cigarettes
- ☐ Spent on alcoholic Beverages

Personal Information about Supporter

- ☐ Personal identification such as passport or driver's license.
- ☐ Health Insurance coverage letter or health insurance card
- ☐ Immigration documents (your work permit, Permanent Residency Certificate, Residency and Employment Rights Certificate or Caymanian Status document).
- ☐ Proof of residential Address.
- ☐ Proof of postal address.
- ☐ Proof of Needs Assessment assistance or any other social servicer assistance.
- ☐ Proof of assistance sought from any other non- profit organization.

For official use only

- ☐ Completed application form (16 pages)
- ☐ Diagnosis
- ☐ Completed information release form
- ☐ Bills quotation
- ☐ Letter from Health Insurance provider
- ☐ Other relevant information
- ☐ Supporting documents

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Patient Declaration

As evidenced by my signature below, I declare that to the best of my knowledge all information provided, in this application and any supporting documentation, to the Cayman Islands Cancer Society is true and complete. If assistance is granted, I agree to advise the Society of any change to the information I have provided.

I, further, understand that any assistance will stop immediately upon death of the cancer patient and may stop at any time at the absolute discretion of the Society.

_____	_____	_____
Client or Applicant's Signature	Client or Applicant's Name	Date
_____	_____	_____
Witness' Signature	Witness' Name	Date

Application and documents received by:

_____	_____	_____
CICS Representative Signature	CICS Representative Name	Date

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