CAYMAN ISLANDS CANCER SOCIETY

Financial Aid Policy 2020

The Cayman Islands Cancer Society provides Financial Assistance to Cancer patients who reside in the Cayman Islands for an uninterrupted period of more than 24 months, who are legally resident and can provide proof of their residency and who have little or no health insurance to cover the costs of treatment.

Financial Aid is provided on an individual basis and is assessed by the Board of Directors in a timely manner once a completed Financial Aid Application has been submitted along with all relevant diagnosis, release of information, insurance details, estimates and any other information that may be required outside of the noted required information on the application form.

Financial Aid covers 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;
Prosthetic Devices, and
Prescribed Medications.

Financial Aid does not cover the following instances:
Alternative Treatments or Therapies;
Unproven or Experimental Treatment Protocols;
Applications received posthumously;
Funeral Expenses;
Travel related expenses not specifically mentioned including but not limited to Food and Car Rental and
Expenses that are over 30 days prior to the application date.

The Cayman Islands Cancer Society will not endeavour to provide any Financial Aid Applicants/Patients 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 Board of Directors.

Failing to disclose any relevant information, providing false information or failing to advise of any change of financial circumstances after assistance has been provided may result in assistance being denied or stopped immediately as the case may be and the Society may request that any assistance provided be re-paid within 10 days upon receipt of a written request from the Society. Any assistance will stop immediately upon death of the cancer patient and may stop at any time in the absolute discretion of the Society.

The Cayman Islands Cancer Society provides financial assistance to qualified patients, and their families, who have been diagnosed with cancer. In order for us to assess your eligibility there is a series of forms that we need you to complete. You will also be required to provide supporting documentation.

1. 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 requesting that information on any other organization that may be providing or is considering the provision of financial aid.

Please understand that all applications are reviewed on a case by case basis and that failing to disclose any relevant information, providing false information or failing to advise of any change of financial circumstances after assistance has been provided may result in assistance being denied or stopped immediately as the case may be. Additionally, in such circumstances, the Society may request that any assistance provided be re-paid and by signing this application you will agree to do so within 10 days upon receipt of a written request from the Society. Finally, please understand that any assistance will stop immediately upon death of the cancer patient and may stop at any time in the absolute discretion of the Society.

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.

3. Release of Information

It may also be necessary for us to obtain information from your health insurance provider or other individuals and we therefore ask that you also complete the enclosed form 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 we ask that you attach a quotation for anticipated costs you will incur.

5. Health Insurance Coverage Letter

We will require a letter from your health insurance company stating what portion of your bills is not covered.

6. Other Relevant Information

You may also include any other information that you feel is relevant.

Once your application is received, it will be forwarded to the Board of the Cayman Islands Cancer Society who will make every effort to render a decision within seven (7) working days of the receipt of your request.

Should you require any additional information or wish to check on your application, please call us at 949-7618 or email info@cics.ky

Yours sincerely

Cayman Islands Cancer Society

114 Maple Road · George Town
P.O. Box 10565 · Grand Cayman KY1-1005 · Cayman Islands
T. 345-949-7618 · F. 345-949-8694 · E. info@cics.ky · W. www.cics.ky

May we have the Cancer Registrar contact you about registering?

☐ Yes, I want to help

Name:____

Phone:____

Email:____

☐ No, thank you.

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 management and prevention strategies. Registering is fast and easy.

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APPLICATION FOR FINANCIAL ASSISTANCE

Please answer all questions. If a question is not applicable to you please answer N/A. If you need additional space to answer any question please use the space provided the **Additional Information** page of this application.

Date: ___________________

Client Information

Client's (Patient) Name: ____

Surname First Name Middle Initial

Other Name's that you are known by: ____

Gender (circle appropriate answer): Male / Female

Date Of Birth (dd/mm/yy): _____________________________________Age: _______________________________

Home Phone:_________________Work Phone:_________________Cell Phone:_____________Fax:_____________

Email:____

Mailing Address: P.O. Box __________________Island:_____________________Postal Code:__________________

Home Address: House Number:______________________________Street:__________________________________

District:____

Directions to House:____
____

Do you own or rent the property? (circle appropriate answer) OWN / RENT

Period of Lease, if rented?____

Marital Status (circle appropriate answer): Single Married Divorced Separated Widowed

Resident Status (circle appropriate answer):

Caymanian Residency and Employment Rights Certificate Holder

Permanent Resident Work Permit Holder

Length of residency (if not Caymanian):____

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

If YES what is your disability? ____

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Client's Employment Information

Are you employed? (circle appropriate answer) YES / NO

Name of Employer and position: ____

Address: ______________________________ Phone Number: ____________________

Supervisor's Name: ____

If you are unemployed please state reason(s) for unemployment: ____________________

____

Type of Financial Aid being requested: ____

____

Insurance Information

Do you have medical insurance (circle appropriate): YES / NO

If NO please 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: ____

____

Other Agencies

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 case worker's name:

____

Address:___________________________Phone Number:__________________Email Address:_____________________

How long have you been seeing them? ____

Have you requested financial assistance from other organisations or fundraisers 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

Banking / Savings Institution: ____

Address: ______________________________________ Phone Number: _________________

Balance in all accounts: CI$_____________ US$____________ Other__________________

List any Assets owned such as property, land, businesses –

____

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$____________	per month
Fundraisers such as GoFundMe, Charity Walks, Donation Cans, etc (other organizations or service clubs)		
TOTAL INCOME	**CI$____________**	**per month**

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$________	per month	Internet/Wi-Fi	CI$________	per month
Domestic Helper	CI$________	per month	Care Giver	CI$________	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**

Family Information of Client

Supporter's Name :____

Surname First Name Middle Initial

Relation to You (if related): ____

Mailing Address (if different from the Client):

P.O. Box ________________________ Island: __________________________ Postal Code: _______________

Home Phone:______________ Work Phone: _____________ Cell Phone: _______________ Fax: ______________

Email:____

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

Surname First Name Middle Initial

Relationship to Client:____

Number of dependents (living at home or otherwise) : ____________________________________

Household Members	Full Name	Date of Birth (dd/mm/yy)	Age	Nationality	Occupation

Spouse/Partner's Employment Information (if applicable)

Name of Employer and positon: ____

Address: ____ Phone Number: __________________________

Email Address: ____

If unemployed please state reason for unemployment:

____

____

____

____

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CAYMAN ISLANDS CANCER SOCIETY

Additional Information

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 its duly authorized representative, any information deemed necessary to complete its assessment of my application for Financial Assistance including but not limited to:

- ❑ Medical History;
- ❑ Medical Billing;
- ❑ Medication Costs;
- ❑ Insurance Coverage;
- ❑ Terms of Employment (limited to remuneration, sick pay, insurance coverage);
- ❑ Bank balances;
- ❑ Assistance being provided.

This authorization lasts for a period of twelve months and may be renewed by me by submitting a new authorization for release of information form.

Client's Name: ________________________________ Date Of Birth (dd/mm/yy): ____________________________

Other Names (that you are known by): ____________ ____

Mailing Address: ____

Telephone Number:

Home: _______________________________Work: ___________________________ Cell: ___________________

Witness' Name (please print) ____

Witness' Signature: ____Date________________________

Client's Signature: ____ Date: ________________________

Please provide the following information if known:

Medical Record # (if available) ____

Health Insurance Provider: ____

Group Policy #: __________________________________ Individual Policy #:_______________________________

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To Whom It May Concern:

Re: ____

Attached is an Authorization for Release of Information from the above named patient who is requesting financial assistance with their medical bills from the CICS.

1. Primary Cancer:_________________________________ 2. Date of Diagnosis ________________

3. Stage of Cancer: __________________ 4. Is this ☐ A new diagnosis or ☐ A recurrence

5. Additional Diagnosis Information: ____

____

6. Prognosis: ____

____

7. Is the patient currently receiving treatment? ☐ YES ☐ NO

8. If YES, please circle all that apply. If NO please go to Question 10

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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Cayman Islands Cancer Society Financial Aid Application
Checklist of required documents

For the Patient

Please provide copies of the following –

Personal information

- ☐ 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 services assistance.
- ☐ Proof of assistance sought from any other non-profit organisation.

Medical information

- ☐ Written diagnosis from your Doctor.
- ☐ Medical bills.
- ☐ Quotes for treatment.
- ☐ Airfare costs
- ☐ Accommodation costs.
- ☐ Medical itinerary.
- ☐ Treatments received.

Financial Information (documents required from both Patient and Supporter)

- ☐ Your salary and income information. This should include documentation of your salary from employment contract plus any additional income from other sources such as rent, personal business, child support, etc.
- ☐ Bank statements.
- ☐ Information relating to any assets owned such as property, land or businesses.
- ☐ A copy of your lease or any other rent information.
- ☐ Support received from child maintenance.
- ☐ Pension deductibles or pension benefits.
- ☐ Health Insurance deductibles.
- ☐ School fees.
- ☐ Assistance from family or friends received.
- ☐ Any loan information.
- ☐ Credit card information.
- ☐ Gas costs.
- ☐ Car payments.
- ☐ Mortgage information.

- ☐ Water bills.
- ☐ Electricity bills.
- ☐ Television bills.
- ☐ Telephone bills.
- ☐ Internet bills.
- ☐ Domestic Helper salary.
- ☐ Caregiver salary.
- ☐ Groceries.
- ☐ Other meals.
- ☐ Life Insurance.
- ☐ Car Insurance.
- ☐ Child Maintenance.
- ☐ Propane/Gas.
- ☐ Cigarettes.
- ☐ 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 services assistance.
- ☐ Proof of assistance sought from any other non-profit organisation.

For office use only

- ☐ Completed application form (16 pages)
- ☐ Diagnosis
- ☐ Completed information release form
- ☐ Bills and quotations
- ☐ 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 above information. I understand that all applications are reviewed on a case by case basis and that failing to disclose any relevant information, providing false information or failing to advise of any change of financial circumstances after assistance has been provided may result in assistance being denied or stopped immediately as the case may be. I understand that in such circumstances the Society may request that any assistance provided be re-paid and I agree to do so within 10 days upon receipt of a written request from the Society. I further understand that any assistance will stop immediately upon death of the cancer patient and may stop at any time in the absolute discretion of the Society.

______________________	______________________	__________
Client or Applicant's Signature	Client or Applicant's Name	Date

______________________	______________________	__________
Witness' Signature	Witness' Name	Date

Received by -

______________________	______________________	__________
CICS Representative Signature	CICS Representative Name	Date

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