THE DIRECT FINANCIAL AID POLICY 2017

Introduction

The Breast Cancer Foundation for the most part delegates responsibility for determining the eligibility for and quantum of direct financial assistance for breast cancer patients and survivors to the Cayman Islands Cancer Society ("CICS"). This is done by way of an annual grant designed to cover the bulk of CICS annual financial assistance grants to breast cancer patients. The reason for this is that The Breast Cancer Foundation does not want to build up the administrative infrastructure required to independently assess individual financial suitability for financial support. CICS has well defined policies and procedures and the staffing to make informed judgments as to the suitability of candidates for financial support.

Exceptions

The Breast Cancer Foundation will consider making exceptions to the above approach in circumstances whereby a breast cancer patient or sufferer has been turned down by CICS on the grounds of either length of time in the Cayman Islands or because the nature of the support does not fall within their approved criteria. In such circumstances The Breast Cancer Foundation will independently assess the financial suitability of the applicant on a one off basis. The responsibility for assessing the initial financial suitability of applicants rests with the Chief Administrator who will prepare a detailed assessment of the case in question and a formal written recommendation to the Board.

In considering recommendations, the Board will consistently apply one overarching criteria, in that the applicant must clearly qualify as not having the wherewithal to cover the uninsured costs associated with the treatment or consequential costs associated with the treatment. To be more specific a candidate will be deemed to be not suitable for financial assistance in the following circumstances.

1. Where the applicant has sufficient savings to cover the costs or consequential costs.
2. Where the applicant is employed and has identifiable future earning capability to cover the costs if they were covered in the short to medium term by the utilization of credit that is readily available to the applicant (for example by way of a bank loan or the use of a credit card facility).

In making an exception to the standard approach of outsourcing the financial assessment effort to CICS, the Board will only consider doing so where the applicant clearly would either be unable to avail themselves of the available treatment without The Breast Cancer Foundations' support, or where the applicant would be placed in a situation of severe ongoing financial hardship that could not readily be relieved in any way in the short to medium term.

Direct Financial Aid may be granted at the sole discretion of the Board of Directors, and should any false information be provided or a change in financial circumstances fail to be advised to the Board, then assistance will be denied or stopped immediately and full repayment of any prior assistance provided may be demanded

P.O Box 30189, Grand Cayman, Cayman Islands. KY1 1201
T. (345) 949 3542 C. 923 1135 E. info@breastcancerfoundtion.ky www.breastcancerfoundation.ky

Approved Expense Categories

The following expenses are eligible for coverage under a pre-approved Financial Aid Grant

- Proven treatment protocols
- Outpatient diagnostic testing
- Laboratory and pathological Services
- Lodging and airfare
- Prosthetic devices
- Prescribed medications
- Other travel related expenses including but not limited to food and car rental at the discretion of the board.

Procedures

The Chief Administrator should compile the following information to support any Direct Financial Aid Recommendation presented to the Board for consideration.

1. CICS Financial Aid form in its entirety, or as abridged to suit individual circumstances.
2. Proof of diagnosis.
3. Health Insurance coverage letter.
4. Confirmation of an application to CICS that has been rejected, or statement as to why an application would be unsuccessful.
5. Availability of credit.
6. Detailed budget for financial aid requested.
7. Formal recommendation from the Chief Administrator explains why the particular case fits within the Foundation's policy.

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APPLICATION FOR FINANCIAL ASSISTANCE

Please answer all the questions, if a question is not applicable to you please answer N/A. If you need addition space to answer any questions, please use the space provided in the "additional information" page.

Date _____

Applicants Details

First Name_____ Last Name _____

Any other name used/known by _____

Male / Female (please delete as appropriate) D.O.B (dd/mm/year)_____

Marital Status (Please circle) Single Married Divorced Separated Widowed

Do you have a disability? (if yes, please give details) _____

Mailing address P.O. Box _____ Island _____ Postal Code KY1 _____

Street Address – House No. _____ Street _____ District _____

Directions to your house _____

Home Phone No _____ Mobile No. _____ Work Phone _____

Email _____

Residence Status (please circle) Work Permit Holder Caymanian Permanent Resident

How long have you lived in Cayman (if not a resident) _____

Family Information

Next of Kin – Name _____ Relation to you _____

Mailing address (if different to applicants) P.O. Box _____ Island _____ Postal Code KY1 _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail address _____

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Dependents – do you have any? If so, please give details:-

Household members	Full Name	DOB (D/M/Y)	Nationality	Occupation

Have you applied to the CI Cancer Society for financial aid **Yes / No** **(please circle)**

What was the result of that application _____

_____

If refused, what reasons were given _____

_____

Type of financial aid being requested

_____

_____

_____

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Medical Information

Name of your doctor(s) in Cayman _____

Doctor(s) location(s) _____

Doctor(s) phone number(s)_____

Date of last visit _____

Any other Doctors, treating you abroad? Please give their details, name and contact information _____

Date of last visit_____

Diagnosis _____

Date of Diagnosis _____

What treatments have you received to date? (include surgeries and dates for those surgeries_____

When is your next scheduled treatment date _____ **where will that be?** _____

Employment Information

Name of Employer _____

Address of Employer _____

E-mail and phone number of employer _____

If you are unemployed please state reason for unemployment _____

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Insurance Information

Do you have medical insurance YES / NO (please circle)

If yes, please give us the details of your insurance, name of company, Policy ID, Employee Number, their address and contact details (e-mail and phone number) and a contact person.

What does your insurance cover? _____

Financial Information

Name of your bankers / saving institution _____

Address _____ phone number _____

Balance in all accounts CI$ _____ US$_____ Other _____

List any Assets owned by you (i.e. house, land etc.) _____

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Monthly income

Employment	**CI$ _____ per month**
Spouses Employment	**CI$ _____ per month**
Social Services	**CI$ _____ per month**
Child maintenance	**CI$_____ per month**
Relatives & friends	**CI$ _____ per month**
Pension	**CI$ _____ per month**
Other income	**CI$ _____ per month**
Total Income	**CI$_____ per month**

Monthly expenses

Rent/Mortgage **CI$_____ per month**

Car gas /transportation CI$ _____ per month

Credit Cards	**CI$_____ per month**	**Life Ins CI$_____**	**per month**
Electricity	**CI$_____ per month**	**Phone CI$_____**	**per month**
Domestic Helper	**CI$_____ per month**	**Groceries CI$_____**	**per month**
School fees	**CI$_____ per month**	**Health InsCI$_____**	**per month**
Child Maintenance	**CI$_____ per month**	**Care Giver CI$_____**	**per month**
Bank Loan	**CI$_____ per month**	**Pension CI$_____**	**per month**
Water/electric/gas	**CI$_____ per month**	**Cable TV CI$_____**	**per month**
Car Insurance	**CI$_____ per month**	**Garbage feesCI$_____**	**per month**

Miscellaneous **CI$_____ per month (please give details) _____**

Total Expenses **CI$_____ per month** **Surplus or deficit CI$_____ per month**

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I _____ declare to the best of my knowledge, all the information provided in this application form and any supporting information given to the Cayman Islands Breast Cancer Foundation (BCF) is true and complete. If financial assistance is granted I agree to advice the BCF of any change(s) to the information I have supplied today. I fully understand that all applications are considered by the Board of the BCF on an individual basis and aim to be fair and consistent. I understand that failing to disclose any relevant information or providing false information or failing to advise of any change of financial circumstances after assistance has been provided to me, that it may result in further assistance not being provided and may result in assistance being denied or stopped immediately as the case may be. I also accept and understand that in such circumstances the BCF may ask for re-payment and I agree to do so within 10 days upon receipt of a letter from the BCF requesting such repayment. I also understand that financial assistance can be stopped immediately at the discretion of the BCF.

Applicants Signature _____ Date _____

Witness Signature _____ Date _____

Witness Name (printed) _____

Received by _____ Print name _____

Date received _____

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Additional information sheet

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Authorization for Release information

I _____ hereby authorise all Doctors, Hospitals, Financial Institutions, Insurance Companies, Department of Children's Services and any other organization that maybe assisting me with my medical expenses, to release to the Cayman Islands Breast Cancer Foundation any information deemed necessary to complete my assessment of my application for financial aid/assistance. Including a not limited to; medical History, medical billing, medication costs, insurance coverage, terms of employment (limited to remuneration, sick pay, insurance coverage), bank balances and assistance being provided.

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

Signature of applicant _____ Date _____

Name (printed)_____

Other names known by _____

Mailing address _____

Telephone No. Home _____ Mobile _____ Work _____

Witnessed by _____ Date _____

Name (printed) _____

PLEASE PROVIDE THE FOLLOWING INFORMATION IF KNOWN:-

Medical record number _____

Health Insurance Police Provider _____

Group Policy # _____

Individual Policy # _____

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TO WHOM IT MAY CONCERN

Re _____ DOB _____

Attached is an authorization for release of information from the above name patient who is requesting financial assistance with their medical bills from the Breast Cancer Foundation.

1. **Primary Cancer _____**
2. **Date of diagnosis _____**
3. **Stage of Breast Cancer _____**
4. **Is this a new diagnosis or a recurrence?_____**
5. **Additional 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 PALLATIVE CARE

OTHER (please specify) _____

9. **Other information regarding treatment _____**
10. **If NO, is Post Treatment follow up needed YES / NO if yes, please explain**

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11. **Other information you feel is relevant** _____

PHYSICIANS SIGNATURE _____ **Date** _____

PHYSICIAN'S NAME _____

Institution _____

Address _____

Phone _____

E-mail _____

Fax _____

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