Financial Aid Policy

Team Nolan Pediatric Program, the pediatric extension of the Cayman Heart Foundation, raises public awareness and financial assistance to families in Cayman when their child suffers from a congenital heart defect, assisting them with expenses associated with urgent pediatric cardiology healthcare.

Consideration of financial aid is afforded on a case by case basis and is assessed by Team Nolan Pediatric Program and the Cayman Heart Foundation in a timely manner once a completed Financial Aid Application has been submitted, accompanied with relevant and requested information.

Financial Aid can cover the following instances:
Accommodation or airfare for patient and one immediate family member.
Assistance with utilities, food, time off work, etc.

Team Nolan Pediatric Program will not provide medical opinions, alternative treatment locations and/or advice on 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 Team Nolan Pediatric Program and the Cayman Heart Foundation. Failing to disclose any relevant and/or requested 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 ceased immediately as the case may be and Team Nolan Pediatric Program and the Cayman Heart Foundation may request that any assistance provided be re-paid within 10 days upon receipt of a written request. Any assistance will cease at the absolute discretion of Team Nolan Pediatric Program and the Cayman Heart Foundation. Team Nolan Pediatric Program and the Cayman Heart Foundation reserve its right to amend the terms of the application process from time to time.

In making our decision, it is necessary for a written diagnosis from your child's pediatrician cardiologist to accompany your completed application.

Please attach copies of any relevant materials to your application (eg: bills). If you are seeking assistance with anticipated future expenses, please attach a detailed estimation of such costs, with supporting documentation (eg: copies of past invoices illustrating history of expenses).

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

Once your application is received, it will be forwarded to Team Nolan Pediatric Program who will make every effort to respond within seven (7) working days of the receipt of your request.

We wish you and your family all the very best.

Yours sincerely

Team Nolan Pediatric Program and the Cayman Heart Foundation

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 additional pages as required.

Date of Application: _____

Mother's Information

Name: _____

Surname First Name Middle Initial

D.O.B. (d/m/y): _____

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

Street Address: House #:_____ Street: _____ District:_____

Directions to House: _____Own____Rent____

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

Email: _____

Resident Status (circle appropriate): Caymanian Permanent Resident Work Permit Holder

Length of residency (if not Caymanian):_____

Name of Employer: _____

Address: _____ Phone Number: _____

Supervisor's Name: _____

If you are unemployed please state reason for unemployment: _____

Next of Kin: _____ Relation to You: _____

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

Street Address: House #:_____ Street: _____ District:_____

Directions to House: _____Own____Rent____

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

Email: _____

Resident Status (circle appropriate): Caymanian Permanent Resident Work Permit Holder

Length of residency (if not Caymanian):_____

Employment CI$_____ per month

Social Services CI$_____ per month

Child Maintenance CI$_____ per month

Relatives & Friends CI$_____ per month

Pension (e.g. Seamen) CI$_____ per month

Other: _____ CI$_____ per month

(Other organizations or Service Clubs)

TOTAL INCOME CI$_____ per month

Father's Information

Name: _____

Surname First Name Middle Initial

D.O.B. (d/m/y): _____

Employer:_____ Employed Title:_____

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

Street Address: House #:_____ Street: _____ District:_____

Directions to House: _____Own____Rent____

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

Email: _____

Resident Status (circle appropriate): Caymanian Permanent Resident Work Permit Holder

Length of residency (if not Caymanian):_____

Name of Employer: _____

Address: _____ Phone Number: _____

Supervisor's Name: _____

If you are unemployed please state reason for unemployment: _____

Next of Kin: _____ Relation to You: _____

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

Street Address: House #:_____ Street: _____ District:_____

Directions to House: _____Own____Rent____

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

Email: _____

Resident Status (circle appropriate): Caymanian Permanent Resident Work Permit Holder

Length of residency (if not Caymanian):_____

Employment CI$_____ per month

Social Services CI$_____ per month

Child Maintenance CI$_____ per month

Relatives & Friends CI$_____ per month

Pension (e.g. Seamen) CI$_____ per month

Other: _____ CI$_____ per month

(Other organizations or Service Clubs)

TOTAL INCOME CI$_____ per month

Patient's Information

Child's (Patient) Name: _____

Surname First Name Middle Initial

Gender (circle appropriate): Male / Female D.O.B. (d/m/y): _____

Child's Medical Information

Diagnosis:_____

Type of financial aid being requested:_____

(eg: utility bills, food costs, air fare, accommodation, mortgage/rent, time off work, car hire, other)

Referral Source:_____

Name of Child's Doctor (in Cayman & overseas):_____

Doctor's Location: _____ Phone Number: _____

Date of last visit: _____ Date of next visit: _____

Doctor's Location: _____ Phone Number: _____

Date of last visit: _____ Date of next visit: _____

What treatments has child received to date (please include surgeries and list dates):_____

_____

Details of required care/treatment: _____

Child's Medical Insurance

Is the Child a dependent on medical insurance (circle appropriate): YES / NO

If NO please state reason: _____

If YES – Name of Company: _____Policy ID_____Employee #_____

Address: _____ Phone Number: _____

Contact Person: _____

What Does Your Insurance Not Cover? _____

Household Monthly Expenses:

Rent / Mortage	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$_____ per month	Propane Gas	CI$_____ 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$_____ per month	Garbage Fees	CI$_____ per month
Personal	CI$_____ per month	Other (please list)	CI$_____ per month

TOTAL EXPENSES **CI$_____ per month**

SURPLUS / DEFICIT **CI$_____per month**

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 Team Nolan Pediatric Program and the Cayman Heart Foundation is true and complete.

_____	_____	_____
Mother's Signature	Print Name	Date
_____	_____	_____
Witness Signature	Witness Name	Date
_____	_____	_____
Father's Signature	Print Name	Date
_____	_____	_____
Witness Signature	Witness Name	Date