

WELLNESS PROGRAMME APPLICATION FORM

The Breast Cancer Foundation (BCF) provides support during and after treatment to eligible patients who have been diagnosed with breast cancer. To help us assess your eligibility, please complete this form in full and submit it along with the required supporting documents.

BCF Wellness Programme Application Form

This form must be fully completed at the time of submission.

Diagnosis Documentation

Please provide medical documentation confirming your diagnosis and treatment plan, such as reports, scans, and other relevant documents.

Assistance with Outstanding Bills / Estimates

If you are requesting support for upcoming treatment or related expenses:

- Submit a completed BCF Financial Aid Form.
- Include a quotation or estimate of the anticipated costs.
- Provide a brief explanation of your financial situation and the need for assistance, attaching any relevant supporting documents.

If you are requesting support for existing medical bills or other related expenses:

- Attach a copy of your letter of decline from the Cayman Islands Cancer Society (CICS).
- Include relevant financial documents (e.g., income statements, medical bills).

Health Insurance Coverage

Please submit:

- A letter from your health insurance provider outlining the portion of your bills that are not covered.
- A letter of rejection or non-coverage from the CICS, if applicable.

Other Relevant Information

Include any other information you believe may support your application.

Once your completed application and all required documents have been received, the Wellness Team will begin processing your request.

Yours sincerely,
The BCF Team

PERSONAL INFORMATION

Full Name: Date of Birth: (DD/MM/YY)

Cell Phone Number: E-mail:

Physical Address:

District:

Marital Status: Single Married Divorce Widowed Prefer Not to Say Dependents:

Immigration Status: Caymanian Status Holder Permanent Resident RERC Holder Visitor Spouse of a Caymanian Work Permit Holder

Employed? Yes/No Employer: Job Title:

Emergency Contact Name: Date of Birth: (DD/MM/YY)

Cell Phone Number: E-mail:

DIAGNOSIS & MEDICAL INFORMATION

Name of General Practitioner (GP): GP Clinic:

Name of Oncologist: Oncologist Hospital:

Name of Surgeon: Surgeon Hospital:

Date of Diagnosis: (DD/MM/YY) Country of Diagnosis:

Age at Diagnosis: Stage of Diagnosis:

Type of Breast Cancer:

- Ductal Carcinoma In Situ (DCIS) Invasive Ductal Carcinoma (IDC) Invasive Lobular Carcinoma (ILC) Triple-Negative Breast Cancer
- Inflammatory Breast Cancer Metastatic (Stage IV) HER2-Positive Breast Cancer Other :

Treatment Planned: (Check all that apply)

- Chemotherapy Radiotherapy Targeted Cancer Drugs and Immunotherapy Hormonal Therapy (Endocrine Therapy) Bone-Strengthening Drugs (Bisphosphonates)
- Surgery: Mastectomy – Single Surgery: Mastectomy – Bilateral Surgery: Reconstruction Surgery: Lumpectomy (Partial Removal) Other :

Other Medical Conditions & Medications:

HEALTH INSURANCE

Do you currently have health insurance? Yes No

Insurance Provider (*Check One*):

CINICO BRITCAY AETNA VANGUARD CAYMAN FIRST Other: _____

Policy Number: _____

ADDITIONAL SUPPORT

Our Wellness Programme is designed to support you emotionally, physically, socially, spiritually, as well as financially.

Please check any of the options below that you would like to participate it:

Nutritional Support (Consultation, G2G, etc.) Emotional Support (Counselling, etc)
 WhatsApp Groups Surgical Garments (Compression bras, soft inserts, etc.)
 Post-Op Garments (Prosthetics, bras) Support Groups (In-Person) Other: _____

Are you receiving additional support from any of the following?

GoFundMe Local Fundraiser Cayman Islands Cancer Society (CICS)
 Needs Assessment Unit (NAU) Other: _____

THE CAYMAN ISLANDS CANCER REGISTRY

The Cayman Islands Cancer Registry is a confidential national database that collects basic information about cancer diagnoses in the Cayman Islands. This data is used only for statistical purposes and helps improve cancer prevention, treatment planning, and public health initiatives.

Participation is voluntary, and registration is fast, easy, and fully confidential.

Would you be willing to have the Cancer Registrar contact you directly to provide more information to assist with registration?

Yes No

REFERRAL SOURCE

How did you hear about us? Please select one or more of the following:

Doctor / Healthcare Provider Friend / Family Social Media Website
 Other: _____

CONSENT AND DISCLAIMER

Disclaimer

This programme is available only to residents of the Cayman Islands. All services provided through the Breast Cancer Foundation (BCF) Wellness Programme are subject to assessment and approval.

By signing this form, I, _____, give consent for a representative from the Breast Cancer Foundation to:

- Contact my health insurance provider,
- Contact my medical team.

This consent allows the Breast Cancer Foundation to assist me in accessing the necessary services and support offered through the Wellness Programme.

All applications are reviewed on a case-by-case basis. Approval of assistance is at the sole discretion of the Board of Directors. Failure to disclose relevant information, the provision of false information, or failure to notify the Foundation of any changes in circumstances after assistance has been granted may result in the immediate termination of support and disqualification from receiving further assistance.

All assistance will cease immediately upon the death of the patient.

Patient Signature

Date

Thank you for applying to the Breast Cancer Foundation Wellness Programme. **We are here for you.**

For Official Use Only

Application Received On: _____

Application Received By: _____

Outcome:

- Approved Not Approved