THE LADY CUBITT COMPASSIONATE ASSOCIATION

Founded by Lady Cubitt 1932 – Incorporated 1945

PATIENT INFORMATION FORM

FileMaker Pro Patient ID# _____

Date: _____

Patient Information

Full Name: _____

First *Middle* *Last*

Date of Birth: _____ MALE FEMALE

Marital Status (circle one):

Single	Partner	Married	Separated	Divorced	Widow(er)

Spouse/Partner:

Name of Spouse/Partner:	
Spouse/Partner Birthdate:	
Spouse/Partner Workplace:	

Address: _____

Apartment/Unit # *Street Address*

_____

Parish *ZIP Code*

Phone: _____ **Cellular:** _____

E-mail: _____

Employer: _____ **Years:** _____

Address: _____ **Position:** _____

Work Ph: _____ **Cellular:** _____

E-mail: _____

Department of Financial Assistance Client:	YES	NO

If Yes:

Social Worker:		**Transfer Social Worker:**	

Insurance Company (Please circle):

None	Colonial	MASA / Moongate	GEHI	HIP	Future Care
Policy Number:		Certificate Number:		Other:	
Additional Information:					

Owns Residence:	YES	NO	**Owns Other Property:**	YES	NO

Medical Information

Physician: _____ **Physician (Referred):** _____

Medical Social Worker: _____ **Air Ambulance:** YES NO

Diagnosis: _____

Treatment: _____

_____

Medical Center: _____

Accommodations: _____

Travelling Companion: _____

Estimated Cost: _____ **Advanced Payment:** _____

Appointment Date: _____ **Expected Departure Date:** _____

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Next of Kin Information

#1 Full Name: _____
First *Middle* *Last* *Relationship*

Date of Birth: _____ MALE FEMALE

Address: _____
Apartment/Unit # *Street Address*

_____
Parish *ZIP Code*

Phone: _____ **Cellular:** _____

E-mail: _____

Employer: _____ **Years:** _____

Address: _____ **Position:** _____

Work Ph: _____ **Cellular:** _____

E-mail: _____

#2 Full Name: _____
First *Middle* *Last* *Relationship*

Date of Birth: _____ MALE FEMALE

Address: _____
Apartment/Unit # *Street Address*

_____
Parish *ZIP Code*

Phone: _____ **Cellular:** _____

E-mail: _____

Employer: _____ **Years:** _____

Address: _____ **Position:** _____

Work Phone: _____ **Cellular:** _____

E-mail: _____

#3 Full Name: _____
First *Middle* *Last* *Relationship*

Date of Birth: _____ MALE FEMALE

Address: _____
Apartment/Unit # *Street Address*

_____
Parish *ZIP Code*

Phone: _____ **Cellular:** _____

E-mail: _____

Employer: _____ **Years:** _____

Address: _____ **Position:** _____

Work Phone: _____ **Cellular:** _____

E-mail: _____

Statement (circle one):

Yes	No	If Yes:	Mail	E-mail

Notes:

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GUARANTOR INFORMATION FORM

FileMaker Pro Guarantor ID# _____

Guarantor Information

Full Name: _____ **Relationship:** _____
First *Middle* *Last*

Date of Birth: _____ MALE FEMALE

Address: _____
Apartment/Unit # *Street Address*

_____
Parish *ZIP Code*

Phone: _____ **Cellular:** _____

E-mail Address: _____

Statement (circle one):

Yes	No	If Yes:	Mail	E-mail

Marital Status (circle one):

Single	Partner	Married	Separated	Divorced	Widow(er)

Spouse/Partner:

Name of Spouse/Partner:	
Spouse/Partner Birthdate:	
Spouse/Partner Workplace:	

Dependents (circle one): YES NO

List Dependents:

#	First Name	Last Name	Birthdate	Sex	School	Other
1.						
2.						
3.						
4.						
5.						

Primary Employers Details

Employer: _____ **Years:** _____

Address: _____ **Position:** _____

Work Phone: _____ **Cellular:** _____

E-mail Address: _____

Previous Job: _____ **Years:** _____

Position: _____

Secondary Employers Details

Employer: _____ **Years:** _____

Address: _____ **Position:** _____

Phone/Cellular: _____

E-mail: _____

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Financial Information

	Yes	No	Comments
Applicant of Department of Financial Assistance			

	Yes	No	If Yes, please describe:
Owns Residence			
Owns other Property			
Owns Car			
Any Debt?			
Any Loans/Mortgage			

Total Monthly Income		Total Monthly Expenses	
Salary		Rent	
Secondary Income		Mortgage	
Rents		Telephone/Cell	
Child Support		Electricity	
Financial Assistance		Groceries	
Pension		Cable	
		Internet	
TOTAL		TOTAL	

Give particulars of any pertinent information:

Disclaimer and Signature

I certify that the particulars given on both sides of this form are correct.

I further recognize that if any statements given are falsified, that this will constitute fraud.

I authorize the release of information to and from Social Services Department or any other Agency to enable LCCA to make a justified evaluation of my application.

Signature: _____ **Date:** _____

Print Name: _____

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GUARANTOR INFORMATION FORM

FileMaker Pro Guarantor ID# _____

Guarantor Information

Full Name: _____ **Relationship:** _____
First *Middle* *Last*

Date of Birth: _____ MALE FEMALE

Address: _____
Apartment/Unit # *Street Address*

_____
Parish *ZIP Code*

Phone: _____ **Cellular:** _____

E-mail Address: _____

Statement (circle one):

Yes	No	If Yes:	Mail	E-mail

Marital Status (circle one):

Single	Partner	Married	Separated	Divorced	Widow(er)

Spouse/Partner:

Name of Spouse/Partner:	
Spouse/Partner Birthdate:	
Spouse/Partner Workplace:	

Dependents (circle one): YES NO

List Dependents:

#	First Name	Last Name	Birthdate	Sex	School	Other
1.						
2.						
3.						
4.						
5.						

Primary Employers Details

Employer: _____ **Years:** _____

Address: _____ **Position:** _____

Work Phone: _____ **Cellular:** _____

E-mail Address: _____

Previous Job: _____ **Years:** _____

Position: _____

Secondary Employers Details

Employer: _____ **Years:** _____

Address: _____ **Position:** _____

Phone/Cellular: _____

E-mail: _____

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Financial Information

	Yes	No	Comments
Applicant of Department of Financial Assistance			

	Yes	No	If Yes, please describe:
Owns Residence			
Owns other Property			
Owns Car			
Any Debt?			
Any Loans/Mortgage			

Total Monthly Income		Total Monthly Expenses	
Salary/Primary Income		Rent	
Secondary Income		Mortgage	
Rents		Telephone/Cell	
Child Support		Electricity	
Financial Assistance		Groceries	
Pension - Government		Cable	
Pension - Private		Internet	
TOTAL		**TOTAL**	

Give particulars of any pertinent information:

Disclaimer and Signature

I certify that the particulars given on both sides of this form are correct.

I further recognize that if any statements given are falsified, that this will constitute fraud.

I authorize the release of information to and from Social Services Department or any other Agency to enable LCCA to make a justified evaluation of my application.

Signature: _____ **Date:** _____

Print Name: _____

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Fax: 441-295-7147
E-mail: info@lcca.bm

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26 Bermudiana Road
Hamilton, HMM 11
Bermuda

P.O. Box HM 64
Hamilton HM AX
Bermuda

PATIENTS GOING OVERSEAS FOR TREATMENT

PATIENT COVERAGE

The Lady Cubitt Compassionate Association (LCCA) acts as an agency to aid patients without 'Major Medical' health insurance going abroad for medical services not available locally.

Immigration authorities, hospitals, physicians and surgeons in other countries require secure financial guarantees of payment of their charges for such medical services. They will not readily accept ill travelers who might prove to be a financial burden. The LCCA will provide financial guarantees to hospitals and professionals providing care abroad to facilitate acceptance of such patients as the LCCA pre-approves for such treatment.

The Bermuda Government provides the LCCA with an annual grant to fund payment of overseas medical. The LCCA must carefully manage these limited grant funds and allocate them as effectively as possible to the continually escalating costs of medical care overseas incurred by approved patients. Consequently, stringent guidelines have been established for the use of grant funds.

MANAGED CARE PROVIDER - GMMI

The LCCA has appointed Global Medical Management Incorporated (GMMI) as it care management service provider (previously known as CMN), to manage care for patients overseas generally, and for each individual patient specifically, including arranging discounts on charges of care providers, advising on selection of care providers, reviewing such charges as rendered, coordinating and presenting invoices for such charges, collecting and remitting payments on to the care providers. GMMI needs access to all information relating to the treatment in order to carry out its functions. GMMI charges fees for its services, calculated on actual savings achieved for the patient.

LCCA ASSISTANCE QUALIFICATION

The LCCA will process patients for assistance only in cases where the treatment and associated costs will be covered by the patient's health insurance, if any, the patient's own or family's private means and, when needed and available, the grant funds. The LCCA neither approves nor denies applications for overseas medical treatment. Final approval is the sole responsibility of the Chief Medical Officer.

To qualify for the aid and to establish the patient's need for the treatment, the patient's personal physician or surgeon must refer and the Chief Medical Officer of the Department of Health must approve the application to the LCCA. The must patient must provide to the LCCA details of their health Insurance coverage and financial circumstances to determine how the cost can be covered by the insurance, contribution by the patient and/or family and (where necessary and available) by grant funds.

MEDICAL COSTS PROCEDURES

The LCCA will request quotations on the procedures and treatments from at least three approved overseas providers through GMMI. The LCCA will pass the quotations on to the Chief Medical Officer, the referring physician and/or specialist if requested, the patient and family, and (where appropriate) the KEMH Medical Social Workers. They will use the quotations to estimate the projected costs of the treatment, and to select the overseas providers best suited to the patients needs and means.

If the patient and/or family can set up satisfactory financial arrangements to pay the treatment costs fully as they fall due, then the LCCA will deal with the cost accordingly. Otherwise, the patient and/or family will be required to pay the LCCA in advance a deposit of 50% of the projected costs, and agree to an arrangement for repayment of the balance - usually by periodic installments. Because the patient's health insurance benefits cannot be reliably estimated, they cannot be taken into account in determining how much the patient will need to commit to repay. However, the patient's insurance benefits will be applied to the costs when the patient's insurer pays them in due course, and so reduce the balance due from the patient directly.

PRIOR TO PATIENT DEPARTURE

The patient and/or family must sign an agreement for repayment in such terms as the LCCA may require. Take note that in the event of the patient or family defaulting under such agreement without good cause, the LCCA may place the collection of such costs in the hands of a collection agency, attorneys and if necessary commence suit in the courts to recover them.

On behalf of the Government of Bermuda the LCCA will issue through GMMI guarantees to pay all charges for **pre-approved** care and services by the facility (at the least expensive ward rate), the physician or surgeon and other associated services provided to the patient.

The patient and/or family must pay the patient's ordinary air and other fares to and from, and, in the case of outpatient treatment, room and board at the treatment location abroad. The LCCA cannot assist with the costs of any accompanying person.

AFTER TREATMENT

The LCCA will act as the central agency for receipt and rendering invoices for the charges (after review by GMMI), and the collection and payment of those invoices. Accordingly, if the patient should receive any invoices or statements relating to the treatment, the patient must deliver them to the LCCA's office without delay.

LCCA GUARANTOR AGREEMENT

I agree to refund the LCCA all monies expended by the LCCA and, in any case, to indemnify the LCCA against all liability under the guarantee of charges for hospital, medical, surgical and other treatment abroad for

_____.
Patient Name

I agree to pay the actual expenses in full within 30 days after my receipt of each of the LCCA's statement (s) of account for such expenses.

_____.
Signature of Person Responsible

OR

I agree to pay the LCCA a minimum deposit of $ _____, before departure and to pay the balance of the actual expenses in full:

I. within 30 days after my receipt of the LCCA's statement(s) of account for such expenses, or
II. by equal installments of BD$ _____ each payable monthly until full payment.

I authorize the LCCA to claim all health insurance benefits to which I am entitled and to apply them fully to payment of such expenses.

I agree that in the event of my default in any agreed payment then the entire balance of such expenses shall become immediately due and payable to the LCCA, that I will pay to the LCCA interest at such current market rate as the LCCA shall notify me, calculated from the date of default, on the entire unpaid balance of such expenses, and will pay, reimburse for and indemnify the LCCA against all costs on a full indemnity basis; including collection agency and/or legal fees on attorney-client basis.

I authorize the LCCA to:

1) claim, collect and apply to such expenses (including collection of cost) out of all funds raised voluntarily or otherwise on behalf of the patient, in priority to any other claims by or on behalf of the patient;
2) clam against, collect from and apply to payment of all such expenses the patient's benefits under his or her health insurance policy or policies;
3) report to the patient's health insurer and GMMI the diagnosis, proposed treatment and other relevant information and to obtain from the insurer approval of coverage of such treatment, at any time;
4) release to the patient's health insurer and GMMI any information in the LCCA's possession related to such treatment and expenditure;
5) release to the LCCA's collection agents and attorneys any information in the LCCA's possession related to such treatment and expenses.

I release and indemnify the LCCA from and against (whether or not pre-approved) all claims, actions, damages, recoveries, awards, costs, expenses, liabilities arising from such hospital, medical, surgical and other treatment abroad and any travel associated therewith and any other cause occuring during such travel, treatment, recuperation or other period of residence abroad.

I further authorize GMMI to have full access to my medical and associated accounting records maintained by hospitals, physicians, surgeons and others providing care to me in the course of my treatment.

I understand that this is a legally binding agreement.
PAYMENT ACCOUNT: HSBC Bermuda #010-287209-002 - Specify Patient name first, then who payment is from.

Date: _____

Patient Signature: _____ Print Name: _____

Witness: _____

Signature of Person Responsible: _____ Print Name: _____

WItness: _____

Signature of Person Responsible: _____ Print Name: _____

Witness: _____

Signature of Person Responsible: _____ Print Name: _____

Witness: _____