Home Health Care (HHC)
Application and Requirement Guidelines
Groups: 30100, 30101 & 30102 only

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician and approved by the Chief Medical Officer (CMO) which is reviewed at **least** every **180** Days it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

CINICO Policy holder INITIAL requirements

1. Complete the Home Health Care Application Form
2. HHC must be approved by a physician at the CIHSA as well as the CMO
    - Defined care level (1, 2 or 3) must be selected.
    - Plan structure
    - Time frame defined
    - Recertification guidelines (3 or 6 months)
3. All documents required in **A or B** below must be submitted to CINICO for approval.

CINICO Policy holder CONTINUING requirements

1. Copy of all recertification's of HHC from CIHSA/CMO
2. Copy of all contract renewals (Individual Caregiver/HHC Vendor)

Service provision type and requirements (A or B)

A. Care provider employed directly by CINICO member
    - Limited to Level # 3 only – unless specifically approved
    - Employment contract & Statement of working conditions between policy holder & employee.
    - Care provider must be certified in CPR and First Aid
    - Work Permit approval letter (if expatriate)
    - Proof of medical insurance
    - Proof of pension (if applicable)

B. Home Healthcare Vendor:
    - Must have licenses from appropriate CI Authorities (HIC, T&B Immigration, etc.)
    - All employees providing care must have credentials in accordance with level of care
    - All invoices must be signed by CINICO policy holder or designate/guardian and vendor employee
    - All CINICO policy holder contracts must be presented to CINICO *

* Terms and period of contract cannot exceed CIHSA/CMO approved plan or recertification

Telephone: 345-949-8101
Fax: 345-949-8226
Cayman Centre Units 4&5 P.O. Box 10112
Grand Cayman KY1-1001, B.W.I.

Member Name: _____

CINICO ID #: _ _ _ - _ _ - _ _ _ _

Home Health Care Levels and Selection Form

(To be completed by attending CIHSA Physician & CMO)
(Groups: 30100, 30101 & 30102 only)

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician and approved by the Chief Medical Officer which is reviewed at **least** every **180** Days it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient

Select 1 Level only

☐ **Level 1** - Registered Nurses and Licensed Practical Nurses must hold and maintain a valid license to practice issued by the Cayman Islands Health Practice Commission. Plus up to date CPR certification.

Care required in a home setting for patients recovering post-operatively to enable them to leave the hospital setting sooner, or for patients receiving treatment such as chemotherapy, pain management. Caregiver is expected to administer prescribed drugs in the home setting and perform dressing and wound management in association with the GP or Physician prescribed plan structure. (Also Level 2 & 3 care).

☐ **Level 2** - Nursing Assistants - must have a background in health care, evidence of some formal training although it is not essential to hold a professional qualification. NVQ training level 1 or equivalent. CPR and First Aid essential.

Care provider is capable of delivering basic nursing care, such as turning, changing, bathing and feeding a patient. They are permitted to take and record BP and other vital signs and recognising changes outside the normal range. They are also capable of observing changes in a patient's condition and alerting medical assistance and works closely with the Physician. Written reports of care are maintained. (Also Level 3 care)

☐ **Level 3** - Care Assistant - No formal training or qualification, but have experience with caring for an individual in the home setting with supporting references of such. Must complete a basic Home Nursing course, and work under the supervision of a Registered or Licensed Practical Nurse for a minimum period of 6 weeks plus hold an up to date CPR and First Aid certification.

Care provider must be able to provide basic care and supervision, assist with light housework and meal preparation. However, they must know how to respond in an emergency until a medical team or ambulance arrives. Note: If they are required only when non-medical care is needed, i.e. mainly provide companionship and supervision, this care would be deemed convalescence, **which is not a covered benefit**.

CIHSA PHYSICIAN & CMO ONLY:				
1. Physicians Name:				
2. Plan Structure:				
3. Timeframe	☐ 1 month	☐ 2 Months	☐ 3 Months	☐ Other _____
4. Patient Equipment Needs:	☐ None	☐ Specify		
5. Recertification	☐ 1 month	☐ 2 Months	☐ 3 Months	☐ Other _____ (Max 180 days)

_____ Physician Signature

_____ CMO Signature and Seal

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CINICO ID #: _ _ _ - _ _ - _ _ _ _

Home Health Care Application Form

(To be completed by CINICO Member and or Guardian)
(Groups: 30100, 30101 & 30102 only)

This form must be accompanied with a signed and approved Home Health Care Service Levels and Selection Form

MEMBER INFORMATION:

1. Last Name:	First Name:	Middle Name:	
2. Street Address:	District:	P.O. Box #:	Postal Code:
3. Gender: Male Female	4. Birth Date (dd/mm/yy):	5.Proposed reimbursement for cost for services:	
6.Home Telephone:	7.Work Telephone:	8.Cell Phone:	

A. CARE PROVIDER EMPLOYED DIRECTLY BY CINICO MEMBER:

1. Last Name:	First Name:	Middle Name:	
2. Street Address:	District:	P.O. Box #:	Postal Code:
3. Gender: Male Female	4. Birth Date (dd/mm/yy):		
5. Home Telephone:	6. Work Telephone:	7. Cell Phone:	

B. HOME HEALTH CARE VENDOR:

1. Company Name:			
2. Last Name:	First Name:	Middle Name:	
3. Street Address:	District:	P.O. Box #:	Postal Code:
4. Gender: Male Female	5. Birth Date (dd/mm/yy):		
6. Home Telephone:	7. Work Telephone:	8. Cell Phone:	

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ **Date:** _____

Note: If you are the Legal Guardian of the CINICO member, please provide proof of your capacity