Home Health Care (HHC)
Application Guidelines & Checklist)

Home Health Care is limited to Groups **30100: Civil Servants & Pensioners, 30101: Seafarers & Veterans, and 30102: Indigent**.

A **Home Health Care Plan** must meet these four (4) tests:

1. It must be a **formal written plan** included in the patient's Attending Physician's Report and approved by the Chief Medical Office (CMO) **and must be reviewed at least every 180 days;**

2. It **must state the diagnosis** (including relevant medical information, special requirements, etc.);

3. It must certify that the HHC is **in lieu of Hospital confinement**; and

4. It must **specify the type and extent of HHC required** for the treatment of the patient. All HHC applications are reviewed and authorized by CINICO's Medical Case Management Unit (MCMU). Please note that all HHC contains some quantity of assisted living, and as assisted living is not a covered benefit, the MCMU will review the application for percentage of time utilized exclusively for medical care versus assisted living. Based on this review, the MCMU reserves the right to vary the requested reimbursement and/or period of approval in accordance with established medical guidelines. All HHC Benefits will be effective as per the effective date noted in CINICO's approval letter.
CINICO will not approve HHC coverage where the Caregiver is a relative of the Member by birth or marriage.

Please ensure that all required documents listed in the following checklist are submitted at the time of application as CINICO will not process an incomplete application. All documents must be verifiable upon request (originals or certified copies), and documents can be submitted electronically via HHCCINICO@CINICO.ky .

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Application Checklist

Member's Name: _____

Member ID#: _____

☐ **New Application Checklist**

Members who directly employ a Caregiver	**Members who contract with a HHC Agency**
(Items 1 - 6 are required)	**(Items 1 - 4 and Items A - B are required)**
1. ☐ Completed **CINICO Home Health Care Application Form** including the required Attending Physician's Report with a current CMO approval stamp	
2. ☐ Proof of Professional Qualifications and Certifications **(Levels 1 & 2 only)**	
3. ☐ Proof of CPR & First Aid training **(Level 1, 2 and 3)**	
4. ☐ Employment Reference **(Level 3 only)**	
5. ☐ Copy of Employment Agreement between the Employer & Employee (Caregiver) with wages/salary and duties outlined	☐ A. Copy of Agency's current Trade & Business License
6. ☐ Copy of Work Permit approval letter for Caregiver (if expatriate)	☐ B. Copy of Service Agreement between Member (or representative) and Agency

☐ **Renewal Checklist**

Members who directly employ a Caregiver	**Members who contract with a HHC Agency**
(Item 1 is required.) **Plus: Updated information must also be supplied for Items 2 thru 6, if applicable, and if due to any change to, or expiry of, previously submitted documentation.**	**(Item 1 is required)** **Plus: Updated information must also be supplied for Items 2 - 4 and Items A – B, if applicable, and if due to any change to, or expiry of, previously submitted documentation.**
1. ☐ Newly Completed **CINICO Home Health Care Application Form** including the required Attending Physician's Report with a current CMO approval stamp	

Note: Renewals must be presented 30 days prior to the expiration of the previously approved period, along with all supporting documentation.

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Home Health Care (HHC) Application Form

This form is to be completed by the CINICO Member or their Legal Guardian*. Kindly refer to the HHC Application Guidelines & Checklist or contact CINICO if you have any questions. Please complete every section. If not applicable, then kindly write N/A.

☐ New ☐ Renewal

This form must be accompanied by a completed "Application for Home Health Care – Attending Physician's Report".

MEMBER INFORMATION:	**MEMBER ID NUMBER: _ _ _ - _ _ - _ _ _ _ - _ _ _**	
1. Last Name:	First Name:	Middle Name:
Nickname/Alias:		
2. Street Address:	District:	P.O. Box #: Postal Code:
3. Gender: Male ☐ Female ☐	4. Birth Date (dd/mm/yy):	5. E-mail Address:
6. Home Telephone:	7. Work Telephone:	8. Cell Phone:

COMPLETE EITHER SECTION A OR B

A. CAREGIVER EMPLOYED DIRECTLY BY CINICO MEMBER: (Relatives as Caregivers are NOT permitted)

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. E-mail Address:
6. Home Telephone:	7. Work Telephone:	8. Cell Phone:

B. HOME HEALTH CARE VENDOR: (Relatives as Caregivers are NOT permitted)

1. Company Name:	2. Contact Person:
3.Telephone #:	4. E-mail Address:
5. Name of Caregiver:	
Last Name: First Name:	Middle Name:
6. Street Address: District:	P.O. Box #: Postal Code:
7. Gender: Male ☐ Female ☐	8. Birth Date (dd/mm/yy): 9.E-mail Address:

10. PATIENT'S RELEASE: I, _____, hereby authorize CINICO to release to the above-named Caregiver agency, the letter of response to this application for Home Health Care.

Name: _____ Signature: _____ Date: _____

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Member's name: _____

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

Name: _____*Signature: _____ Date: _____ (dd/mm/yy)

If this form is signed by someone other than the CINICO member, please indicate your relationship below.

- ☐ **Power of Attorney (POA)**
- ☐ **Legal Guardian**
- ☐ **Social Worker**
- ☐ **Next of Kin (NOK)**

Contact Number for POA/Legal Guardian/Social Worker/NOK _____

E-mail Address for POA/Legal Guardian/Social Worker/NOK _____

* Note: If you are the Power of Attorney/Legal Guardian/Social Worker/Next of Kin of our CINICO member, please also provide proof of your capacity along with a copy of a valid ID which includes your signature.

We collect and use relevant information about insureds to provide coverage and for mandated legal purposes. This information includes sensitive personal details including name, address, and medical history. We will process insureds' details, as well as any other personal information provided, in respect of your insurance coverage, in accordance with Cayman Islands National Insurance Company Privacy Policy, a copy of which is available online at https://www.cinico.ky/privacy-policy#b or upon request.

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Application for Home Health Care (HHC) – Attending Physician's Report

Member ID Number: _ _ _ - _ _ - _ _ _ _ - _ _

New HHC Applicant ☐

HHC Renewal ☐

A. Patient Information:

Full Name as on CINICO ID card Last Name: First Name: Middle Name:		
Date of Birth (DD/MM/YYYY):	Gender:	
Street Address:	District:	P.O. Box & Postal Code:
Cell Phone:	Home Phone:	Work Phone:
Contact Person (POA/Legal Guardian/Social Worker/NOK):	Contact Telephone: E-mail Address:	
If currently hospitalized, name of hospital: _____ Is the patient medically cleared for discharge pending HHC? Yes ☐ or No ☐ If no, anticipated date of discharge: _____		

PATIENT'S MEDICAL RELEASE: I, _____, hereby authorize all physicians and medical providers to release to the Cayman Islands National Insurance Company (CINICO), any information acquired during the course of examination and/or treatment which may be relevant to this application for Home Health Care (HHC).

Name: _____ Signature: _____

Date: _____

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B. Current Medical Condition

Patient's name: _____

NOTE: Indicate 'N/A' if an item does not apply to this patient or 'unknown' if the information requested is not known to the physician signing this application.

Age: _____ Weight: _____ Height: _____

Primary Diagnosis:

_____

_____

Secondary Diagnosis(es):

_____

_____

How long have you treated this patient? Weeks _____ Months _____ Years _____

If recovery is anticipated, in how many weeks/months? Weeks _____ Months _____

Is the patient's condition stable? Yes ☐ No ☐

Is it likely that the patient's condition will remain stable or deteriorate? Stable ☐ Deteriorate ☐

Is the patient's condition Chronic ☐ Acute ☐ ?

Has there been, or is there expected to be, deterioration of the patient's functional level? Yes ☐ No ☐

Outline the patient's current medical / physical status:

_____
_____
_____
_____
_____
_____
_____
_____

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Patient's name: _____

Describe in detail the patient's functional mobility, and any assistance and/or assistive devices required.

_____
_____
_____
_____
_____
_____

What are the current therapeutic goals?

_____
_____
_____
_____
_____
_____

Does the patient live alone? Yes ☐ No ☐

If no, with whom does the patient reside? _____

Does the patient currently have a Caregiver?_____

In your professional opinion does this patient require:

- ☐ One (1) Caregiver or
- ☐ Two (2) Caregivers

Please identify Level for:

Caregiver 1:	Level 1	☐	Level 2	☐	Level 3 ☐
Caregiver 2:	Level 1	☐	Level 2	☐	Level 3 ☐

Are there any other aspects of the patient's social, family, medical or home situation which affect the patient's ability to function, or may affect the patient's need for assistance?

_____

_____

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Patient's Name: _____

C. Medical treatment: Please check each type of service which the patient currently requires, and indicate recommended frequency of care (# of times per day/per week). Please also advise how the care is currently being provided.

How many medications? - state number of meds and route if not oral	
Medication Administration	
Monitoring of Vital Signs	
Simple Dressing Changes	
Sterile Dressing Changes	
Mobilization Exercises/Ambulation Assistance	
ROM Rehabilitative Exercises	
Speech/Hearing Therapy Physical/Occupational Therapy/	
Bed Bound Care (turning, repositioning)	
Decubitus care	
Enema	
Tube Irrigation	
Tube Feedings	
Catheter Care	
Ostomy/Colostomy Care	
Oxygen Therapy	
Inhalation Therapy	
Suction Requirements	
Tracheostomy Care	

Patient's name: _____

D. Recommended Caregiver Level

Please select one (1) level only.

If 2 Caregivers are recommended, please provide a separate copy of this page for each one.

Level 1 - Registered Nurse or Licensed Practical Nurse ☐ - Must hold and maintain a valid license to practice, issued by the Cayman Islands Health Practice Commission, with proof of current 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 intravenous therapy / wound care management. The Caregiver is expected to administer prescribed medication / perform dressing changes etc., following physician orders in the home setting. Written reports of care must be maintained. Also responsible for level 2 & 3 care.

Level 2 – Nursing Assistant ☐ - Must have completed a Basic Home Nursing course, NVQ training at level 1 or equivalent, and provide proof of CPR and First Aid certification. The caregiver must be capable of delivering basic activities of daily living such as turning, changing, bathing, and feeding the member. The caregiver must also be capable of taking and recording vital signs, while recognizing changes outside the normal range, in order to report to the member's physician. Must also be capable of observing changes in medical status, seeking medical assistance, and working closely with the member's physician. Written reports of care must be maintained. Also responsible for level 3 care.

Level 3 – Care Assistant ☐ - Must hold a current CPR and First Aid certification. The care provider must be able to provide basic care and supervision, assist with light housework and meal preparation. Must know how to respond in an emergency until a medical team or ambulance arrives. References as evidence of employment as a Caregiver for at least one (1) year are required.

Note: If a care assistant is required only when non-medical care is needed, i.e. mainly to provide companionship and supervision, this care would be deemed convalescent care, which is not a covered benefit.

****Category and exact amount reimbursed is defined by CINICO on a case-by-case basis, based on established medical criteria****

IT IS MY OPINION THAT THIS PATIENT CAN BE CARED FOR AT HOME IN LIEU OF HOSPITALIZATION. I CONFIRM I HAVE ACCURATELY DESCRIBED HIS OR HER MEDICAL CONDITION AND PHYSICAL NEEDS AT THE TIME OF MY EXAMINATION. I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____	_____	_____
Physician's Name	Physician's Signature	Physician's Referral Date

_____	_____
Chief Medical Officer Signature and Stamp	CMO Approval Date

Chief Medical Officer approval is an indication of medical necessity, and is NOT FINANCIAL APPROVAL. Please contact CINICO to determine member's eligibility for this benefit. All Home Health Care benefits must be approved by CINICO.