Medical Assistance Application

Purpose

Arctic Slope Regional Corporation (ASRC) and North Slope Borough (NSB) have granted funds to Arctic Slope Native Association, Ltd. (ASNA) to manage the Medical Travel and Funeral Assistance (MTFA) program. MTFA provides aid to ASRC shareholders and residents of the NSB in medical or funeral crisis when no other alternative funds are available to pay for such services.

This program is for low-income families and families with unforeseen, urgent need for medical travel. Application must be submitted at least five (5) days prior to travel. Exceptions to the five day requirement may be granted for emergencies or unforeseen circumstances.

Program Eligibility Requirements

1. Applicant has been a resident of the North Slope Borough for at least 30 days or is an ASRC Shareholder.
2. Household income during the previous twelve (12) months is less than the Income Guidelines below.
3. Applicant must provide a medical referral from a medical provider.
4. MTFA is available only when all other resources have been exhausted.

2020 ASNA Income Guidelines for MTFA

MTFA Income Guidelines 2020, Based on 2020 Federal and State Poverty Guidelines

Family Size	North Slope (Barrow)		North Slope (Villages)		Anchorage/Fairbanks		Out of State	
	2020 Federal Poverty Guidelines for Alaska	200% of Alaska Poverty Guideline	2020 Federal Poverty Guidelines for Alaska	250% of Alaska Poverty Guideline	2020 Federal Poverty Guidelines for Alaska	135% of Alaska Poverty Guideline	2020 Federal Poverty Guidelines for 48 contiguous states	120% of 2020 Federal Poverty Guideline for 48 Contiguous States
1	15,950	31,900	15,950	39,875	15,950	21,533	15,950	19,140
2	21,550	43,100	21,550	53,875	21,550	29,093	21,550	25,860
3	27,150	54,300	27,150	67,875	27,150	36,653	27,150	32,580
4	32,750	65,500	32,750	81,875	32,750	44,213	32,750	39,300
5	38,350	76,700	38,350	95,875	38,350	51,773	38,350	46,020
6	43,950	87,900	43,950	109,875	43,950	59,333	43,950	52,740
7	49,550	99,100	49,550	123,875	49,550	66,893	49,550	59,460
8	55,150	110,300	55,150	137,875	55,150	74,453	55,150	66,180

For families/households with more than 8 persons,	North Slope (Barrow)	North Slope (Villages)	Anchorage/Fairbanks	Lower 48 States
add the following amount for Each Additional Family Member:	$ 11,200	$ 14,000	$ 7,560	$ 6,720

Client/Escort Responsibility

Client and escorts must read and FULLY UNDERSTAND the agreement. All applications must be completed and submitted by an adult. If the applicant is a minor, an adult must sign and submit on behalf of the minor. The adult signing and submitting the application on behalf of the minor accepts full financial responsibility for any unauthorized costs, expenses or damages incurred or caused by the minor.

Unauthorized Travel

Applicants are strictly prohibited from claiming pre-authorization for travel with airlines before approval. Such claims may result in the applicant being liable for travel costs, and being made ineligible for assistance for up to 2 years.

NOTE: ASNA's ability to provide financial assistance is subject to availability of funds. In the event a shortfall, ASNA will discontinue accepting applications and authorizing benefits.

P.O. Box 0029, Barrow, Alaska 99723 **Toll Free: 1 855-852-9114 Local (907) 852-9114** **Fax Number: (907) 852-9152**

OFFICE USE ONLY:

ASRC_____ **NSB**_____ **Date Application Received** _____

Please print clearly and answer all questions. Incomplete applications will cause delay in processing.

What type of assistance are you applying for?

☐ Medical Travel ☐ Medical Housing

Applicant's First Name, Middle Name, Last Name	Gender	Date of Birth	Social Security Number
(AS SHOWN ON ID or BIRTH CERTIFICATE)			

Physical Address or PO Box	City	State	Zip Code

Applicant's Phone Numbers: Home:_____ Work: _____

Applicant's Cell Phone:_____ E-mail: _____

Have you have been known by any other name, maiden name? ☐ **Yes** ☐ **No**

If yes, by what name(s):_____

Are you a:

North Slope Borough Resident?	☐ **Yes**	☐ **No**
Arctic Slope Regional Corporation Shareholder?	☐ **Yes**	☐ **No**
Village Corporation Shareholder?	☐ **Yes**	☐ **No**

Please indicate the village tribal/corporation in which you are enrolled: _____

Name of Escort (if one has been approved by your medical provider):

First Name, Middle Name, Last Name	Gender	Date of Birth	Cell Phone number
(AS SHOWN ON ID or BIRTH CERTIFICATE)			

Please list the location of your appointment, time and date, and name of case manager or doctor, if known:

_____

_____

_____

Please answer Yes or No: (Do not leave blank.)

Do you or your family have insurance?	☐ **Yes**	☐ **No**
Name of Insurance Company: _____		
Is this a work-related injury?	☐ **Yes**	☐ **No**
· If you answered yes, have you filed for worker's compensation?	☐ **Yes**	☐ **No**

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Do you have Denali KidCare Benefits: ☐ Yes ☐ No
Do you have Medicaid Benefits: ☐ Yes ☐ No
Do you have Medicare Benefits: ☐ Part A ☐ Part B ☐ Yes ☐ No
Are you a U.S. Veteran? ☐ Yes ☐ No

Earned Income: Please list all employers of the adult(s) in the household who have worked within the last 12 months. In addition, include honorariums and loss of pay received from public service(s).

_____

_____

Note: Even if you are not working now, we still need to verify all income earned within the past 12 months.

Do you own a Personal Business? ☐ Yes ☐ No

- If so, Name of Company? _____

(If you answered yes, please submit a Profit/Loss Statement with this application)

Do you own a home and receive Rental Income? ☐ Yes ☐ No

Names of Everyone in Household: Please list the names and dates of birth of all individuals who are living in your household, including any children or dependents age 18 or under (*for whom you are financially responsible*):

Full Name	DOB	SSN	Relationship to Applicant	List Annual Income Amount	Earned or Unearned Income	Source of Income
Example: Jane Doe	*00/00/00*	*000-00-000*	*Mother*	*$ 000.00*	*Earned*	*Name of employer or source.*

I certify that all the information provided on this application is true to the best of my knowledge. I understand I must cooperate with providing any and/or all information upon request to receive assistance from the MTFA Program.

_____ Date: _____
Applicant's Signature

_____ Date: _____
Parent/Guardian Signature required if applicant is a minor child.

NOTE: The adult signing and submitting this application on behalf of a minor is accepting full financial responsibility for any unauthorized costs, expenses or damages incurred or caused by the minor.

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Patient or Client Agreement

This Agreement is entered into between _____ (Name&DOB) and Arctic Slope Native Association (ASNA) for the payment of certain medical travel expenses. Client understands and agrees that failure to comply with any of the terms and conditions of this Agreement shall result in Client owing payment to ASNA of all expenses paid on Client's behalf, or the exclusion of the Client from participation in the Medical Travel and Funeral Assistance program for up to two years. In consideration of the payment by ASNA of medical travel related expenses, Client understands and agrees to the following terms and conditions:

1. Client agrees not use alcohol or illegal drugs on an ASNA funded trip.
2. Client agrees to comply with all local laws and ordinances while on an ASNA funded trip.
3. Client agrees to respect the property of others and to be fully responsible for the cost of damages the Client causes on an ASNA funded trip.
4. Client understands that ASNA has a zero tolerance policy for abusive or harassing behavior. Client agrees to refrain from abusive conduct such as harassment, slander, or duress. Such behavior will be documented and ASNA reserves the right to take legal action against the Client for such behavior, as ASNA deems appropriate.
5. Client agrees to allow only those individuals who are authorized by ASNA to stay in an ASNA-authorized room. No other person, including children, may stay in the room. Client agrees to obtain ASNA's authorization before allowing any person to stay in an ASNA authorized room.
6. Client understands and agrees that ASNA is responsible only for the hotel contract rate, (inclusive of tax and fees). Client agrees to pay for any other charges, including, but not limited to, telephone and food charges.
7. If a physician extends the treatment for which the Client is authorized, the Client agrees to notify ASNA the same day.
8. Client agrees to vacate the ASNA authorized hotel room by the regular hotel checkout time (in most cases 11:00 a.m.) on the last day of Client's stay.
9. Client agrees to attend all appointments/surgeries. Client agrees that ASNA may immediately discontinue payment for medical travel if Client fails to keep their appointment/surgery. If Client fails to attend appointment/surgery, Client agrees to reimburse ASNA for any expenses incurred by ASNA for the travel, and that Client may be disqualified from participating in the medical travel program for up to two years.
10. Client understands and agrees that Client is responsible for any travel claims, including hotel and airline reservations, made prior to ASNA authorization.
11. Client agrees to be bound by the ASNA Medical Travel and Funeral Assistance Appeal Rights Policy and agrees that Policy provides Client with his or her sole exclusive remedy for any disputes concerning Client's participation in ASNA's Medical Travel and Funeral Assistance Program.

By signing below Client acknowledges that he or she understands and agrees to the terms and conditions of this Agreement.

_____ Date: _____

Patient's or Client's Signature

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Escort Agreement

This Agreement is entered into between _____ (Name&DOB) and Arctic Slope Native Association (ASNA) for the payment of certain medical travel expenses. Escort understands and agrees that failure to comply with any of the terms and conditions of this Agreement may result in Escort owing ASNA payment for expenses paid by ASNA for Escort, or exclusion from participation in the Medical Travel and Funeral Assistance program for up to two years. In consideration for receipt of ASNA medical travel funds, Escort understands and agrees to the following terms and conditions:

1. Escort agrees to ensure that the client for who Escort is responsible keeps all of his/her scheduled appointments and any other appointments made during the trip. Escort agrees to accompany the client during their appointments/surgery. Escort agrees to accompany the client home upon completion of the trip.
2. Escort certifies that he or she is either an immediate family member of the Client, or is a responsible adult willing to take on the obligations and requirements set forth in this Agreement.
3. Escort understands and agrees that only the individuals who ASNA authorizes may stay in the room. No other person, including children, may stay in the room. Escort agrees to obtain ASNA's authorization before allowing anyone to stay in an ASNA authorized room.
4. Escort agrees that ASNA is responsible only for the hotel contract rate, (inclusive of tax and fees). Any other charges, such as telephone and food, are the responsibility of the client.
5. Escort understands and agrees that he or she is fully responsible for any damages Escort may cause and will pay for any damages and repairs that Escort is responsible for.
6. Escort agrees not to consume alcoholic beverages or other illegal drugs during any medical travel funded by ASNA. Escort understands and agrees that the trip may be immediately discontinued, and/or that Escort may be denied medical travel benefits for a period of up to two years for violation of this rule.
7. If the treatment for which the client is authorized is extended by the physician, Escort will notify ASNA the same day.
8. Escort agrees to vacate the ASNA authorized hotel room by the regular hotel checkout time (in most cases 11:00 a.m.) on the last day of client's stay.
9. Escort understands and agrees that Escort is responsible for any travel related claims, including hotel and airline reservations, made prior to ASNA authorization.

By signing below Escort acknowledges that he or she understands and agrees to the terms and conditions of this Agreement.

_____ Date: _____

Escort's Signature

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****For Client****

AUTHORIZATION FOR RELEASE OF FINANCIAL INFORMATION

The purpose for this release is to determine financial eligibility of the household member who has asked for assistance from Arctic Slope Native Association (ASNA), Ltd., Medical Travel & Funeral Assistance (MTFA) Program.

I. I,_____, hereby request the disclosure of my financial information.

Social Security Number: _____

II. The financial information is to be released from: (Please check all that apply)

☐ North Slope Borough	☐ Native Village of Nuiqsut	☐ City of Wainwright
☐ North Slope Borough School District	☐ Native Village of Point Hope	☐ SKW Eskimos Inc.
☐ Arctic Slope Regional Corporation	☐ Native Village of Point Lay	☐ Iḷisaġvik College
☐ Ukpeaġvik Iñupiat Corporation	☐ Native Village of Kaktovik	☐ ICAS
☐ Atqasuk Iñupiat Corporation	☐ Naqsragmiut Tribal Council	☐ Arctic Slope Consulting Group
☐ Kaktovik Iñupiat Corporation	☐ Wainwright Traditional Council	☐ Samuel Simmonds Memorial
☐ Kuukpik Village Corporation Tikiġaq	☐ City of Barrow	☐ Alaska Native Medical Center
☐ Corporation	☐ City of Anaktuvuk Pass	☐ Maniilaq Health Center
☐ Cully Corporation	☐ City of Atqasuk	☐ Medicaid
☐ Olgoonik Corporation	☐ City of Kaktovik	☐ PacifiCare Insurance
☐ Nunamiut Inupiat Corporation	☐ City of Nuiqsut	☐ Aetna Insurance
☐ Native Village of Barrow	☐ City of Point Hope	☐ State of Alaska
☐ Native Village of Atqasuk	☐ City of Point Lay	☐ ASNA, Ltd.

☐ **Other Company** _____

III. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature. I understand that if I do not qualify financially I am ineligible for MTFA program services.

Signature:_____ Date: _____

PLEASE DO NOT WRITE IN THIS AREA (PAYROLL & OFFICE USE ONLY)

IV. The Information to be released is for income verification.

- Please state the 12 months total income for the following time period: _____
- Total gross income for the last 12 months: $ _____

If no longer employed, please share date of departure/termination: _____

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****For Spouse****

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☐ Olgoonik Corporation	☐ City of Kaktovik	☐ PacifiCare Insurance
☐ Nunamiut Inupiat Corporation	☐ City of Nuiqsut	☐ Aetna Insurance
☐ Native Village of Barrow	☐ City of Point Hope	☐ State of Alaska
☐ Native Village of Atqasuk	☐ City of Point Lay	☐ ASNA, Ltd.

☐ **Other Company** _____

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Signature:_____ Date: _____

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