# Critical Care Application

***Purpose***

Arctic Slope Regional Corporation (ASRC) and North Slope Borough (NSB) have both granted funds to Arctic Slope Native Association, Ltd. (ASNA) to administer and operate 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.

***Program Eligibility Requirements***

1. Applicant is a resident of North Slope for 30 days and/or an ASRC Shareholder.
2. Applicant must be an immediate family member of the person requiring assistance with critical lifecare decisions, including: spouse, natural or adoptive parent, child, sibling, grandparent, etc.
3. Household income during the previous twelve (12) months is less than the levels identified in the Income Guidelines below.
4. ASNA is the LAST source of assistance. This means all other resources have been exhausted.

***2021 ASNA Income Guidelines for MTFA***

**MTFA Income Guidelines 2021, Based on 2021 Federal and State Poverty Guidelines**

| Family Size | North Slope (Barrow) | | North Slope (Villages) | | Anchorage/Fairbanks | | Out of State | |
|---|---|---|---|---|---|---|---|---|
| | 2021 Federal Poverty Guidelines for Alaska | 200% of Alaska Poverty Guideline | 2021 Federal Poverty Guidelines for Alaska | 250% of Alaska Poverty Guideline | 2021 Federal Poverty Guidelines for Alaska | 135% of Alaska Poverty Guideline | 2021 Federal Poverty Guidelines for 48 contiguous states | 120% of 2021 Federal Poverty Guideline for 48 Contiguous States |
| 1 | 16,090 | 32,180 | 16,090 | 40,225 | 16,090 | 21,722 | 12,880 | 15,456 |
| 2 | 21,770 | 43,540 | 21,770 | 54,425 | 21,770 | 29,390 | 17,420 | 20,904 |
| 3 | 27,450 | 54,900 | 27,450 | 68,625 | 27,450 | 37,058 | 21,960 | 26,352 |
| 4 | 33,130 | 66,260 | 33,130 | 82,825 | 33,130 | 44,726 | 26,500 | 31,800 |
| 5 | 38,810 | 77,620 | 38,810 | 97,025 | 38,810 | 52,394 | 31,040 | 37,248 |
| 6 | 44,490 | 88,980 | 44,490 | 111,225 | 44,490 | 60,062 | 35,580 | 42,696 |
| 7 | 50,170 | 100,340 | 50,170 | 125,425 | 50,170 | 67,730 | 40,120 | 48,144 |
| 8 | 55,850 | 111,700 | 55,850 | 139,625 | 55,850 | 75,398 | 44,660 | 53,592 |

| For families/households with more than 8 persons, add the following amount for Each Additional Family Member: | North Slope (Barrow) | North Slope (Villages) | Anchorage/Fairbanks | Lower 48 States |
|---|---|---|---|---|
| | $ 11,360 | $ 14,200 | $ 7,668 | $ 6,816 |

**NOTE: ASNA's ability to provide financial assistance is subject to the availability of funds. In the event a shortfall occurs and ASNA does not have sufficient funding available to pay for travel, 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**
**MTFA@arcticslope.org**

## Program Information

***Critical Care/Life Decisions Assistance***

If a physician is requesting family to be present to make life decisions for an MTFA client, the MTFA program may award up to two (2) tickets for immediate family members who meet the qualifications of the MTFA program, including the income requirements. A written document from the physician requesting family member to be present must be provided to ASNA MTFA staff members. For patients who already have an escort, one additional ticket can be made based on qualifications. These tickets will be awarded in lieu of Funeral Travel Assistance.



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**OFFICE USE ONLY**

**ASRC_____NSB_____** **Date Application Received_____**

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

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 Phone Numbers: Home_____ Work: _____

Cell Phone:_____ E-mail: _____

Have you have been known by any another 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 which village tribal/corporation you are enrolled: _____

Describe your situation and what you need from ASNA. _____



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| OFFICE STAFF ONLY | | | |
|---|---|---|---|
| **MTFA STAFF:** | | **DATE:** | |
| **SPEAKING TO:** | | | |
| **NAME OF PATIENT:** | | | |

# CRITICAL CARE QUESTIONNAIRE

1. Who is the contact person for your family? (This is the person MTFA Program staff will communicate with.)
    a. Name:
    b. Phone Number:

2. Who will use the two (2) airline tickets provided by ASNA-MTFA?

| NAME | DATE OF BIRTH | GENDER | TO & FROM |
|---|---|---|---|
| | | | |
| | | | |



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**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 currently working, 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.* |
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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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# Critical Care Coordination Travel

## Client Agreement

This Agreement is entered into between _____(Client) and Arctic Slope Native Association (ASNA) for the payment of certain critical care or funeral 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 critical care 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 understands and agrees that Client is responsible for any travel claims, including airline reservations, made prior to ASNA authorization.
6. 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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**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 |
| ☐ Utqiaġvik 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 | ☐ City of Barrow | ☐ Alaska Native Medical Center |
| ☐ Tikigaq 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 | ☐ Aenta 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**

# AUTHORIZATION FOR RELEASE OF FINANCIAL INFORMATION

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Social Security Number: _____

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

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

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Signature:_____ Date: _____

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