

## 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 life care 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.
  - Household/family size only includes adults and dependent children for which you are financially responsible. Adult + spouse + dependent children under the age of 18 = Household = Family Size
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	250% of Alaska Poverty Guideline	2021 Federal Poverty Guidelines for Alaska	300% 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	40,225	16,090	48,270	16,090	21,722	12,880	15,456
2	21,770	54,425	21,770	65,310	21,770	29,390	17,420	20,904
3	27,450	68,625	27,450	82,350	27,450	37,058	21,960	26,352
4	33,130	82,825	33,130	99,390	33,130	44,726	26,500	31,800
5	38,810	97,025	38,810	116,430	38,810	52,394	31,040	37,248
6	44,490	111,225	44,490	133,470	44,490	60,062	35,580	42,696
7	50,170	125,425	50,170	150,510	50,170	67,730	40,120	48,144
8	55,850	139,625	55,850	167,550	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 (Utqiagvik)	North Slope (Villages)	Anchorage/Fairbanks	Lower 48 States
\$ 14,200	\$ 17,040	\$ 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.**

Critical Care & Funeral Assistance Application – FY2022 v1

## **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.

**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 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 which village tribal/corporation you are enrolled: \_\_\_\_\_

Describe your situation and what you need from ASNA. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**Household Member Names & Income:** Please list the names and dates of birth of all dependents who are living in the applicants household under the age of 18, AND the adults/custodians who are financially responsible for the applicant. When reporting income, please include all income earned within the past 12 months, including honorariums and loss of pay received from public service(s).

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

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 MTF A Program.

\_\_\_\_\_  
Applicant's Signature Date: \_\_\_\_\_

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

**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.**



**\*\*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)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> North Slope Borough                 | <input type="checkbox"/> Native Village of Nuiqsut      | <input type="checkbox"/> City of Wainwright            |
| <input type="checkbox"/> North Slope Borough School District | <input type="checkbox"/> Native Village of Point Hope   | <input type="checkbox"/> SKW Eskimos Inc.              |
| <input type="checkbox"/> Arctic Slope Regional Corporation   | <input type="checkbox"/> Native Village of Point Lay    | <input type="checkbox"/> Iļisaġvik College             |
| <input type="checkbox"/> Utqiagvik Iñupiat Corporation       | <input type="checkbox"/> Native Village of Kaktovik     | <input type="checkbox"/> ICAS                          |
| <input type="checkbox"/> Atqasuk Iñupiat Corporation         | <input type="checkbox"/> Naqragmiut Tribal Council      | <input type="checkbox"/> Arctic Slope Consulting Group |
| <input type="checkbox"/> Kaktovik Iñupiat Corporation        | <input type="checkbox"/> Wainwright Traditional Council | <input type="checkbox"/> Samuel Simmonds Memorial      |
| <input type="checkbox"/> Kuukpiik Village Corporation        | <input type="checkbox"/> City of Barrow                 | <input type="checkbox"/> Alaska Native Medical Center  |
| <input type="checkbox"/> Tikigaq Corporation                 | <input type="checkbox"/> City of Anaktuvuk Pass         | <input type="checkbox"/> Maniilaq Health Center        |
| <input type="checkbox"/> Cully Corporation                   | <input type="checkbox"/> City of Atqasuk                | <input type="checkbox"/> Medicaid                      |
| <input type="checkbox"/> Olgoonik Corporation                | <input type="checkbox"/> City of Kaktovik               | <input type="checkbox"/> PacifiCare Insurance          |
| <input type="checkbox"/> Nunamiut Inupiat Corporation        | <input type="checkbox"/> City of Nuiqsut                | <input type="checkbox"/> Aenta Insurance               |
| <input type="checkbox"/> Native Village of Barrow            | <input type="checkbox"/> City of Point Hope             | <input type="checkbox"/> State of Alaska               |
| <input type="checkbox"/> Native Village of Atqasuk           | <input type="checkbox"/> City of Point Lay              | <input type="checkbox"/> ASNA, Ltd.                    |
| <input type="checkbox"/> <b>Other Company</b> _____          |   |  |

**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:** \_\_\_\_\_

**\*\*For Spouse\*\***

### AUTHORIZATION FOR RELEASE OF FINANCIAL INFORMATION

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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- 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: \_\_\_\_\_

OFFICE STAFF ONLY			
<b>MTFA STAFF:</b>		<b>DATE:</b>	
<b>SPEAKING TO:</b>			
<b>NAME OF PATIENT:</b>			

### CRITICAL CARE QUESTIONNAIRE

- Who is the contact person for your family? (This is the person MTFA Program staff will communicate with.)
  - Name:
  - Phone Number:
- Who will use the two (2) airline tickets provided by ASNA-MTFA?

NAME	DATE OF BIRTH	GENDER	TO & FROM