

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.
 - * 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
3. Applicant must provide a medical referral from a medical provider.
4. MTFA is available only when 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

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.

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

 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: _____

Applicant 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

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

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 MTFP 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.

Escort Agreement

This Agreement is entered into between _____ (Escort) 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 share personal contact information with ASNA vendors for travel coordination purposes.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. If the treatment for which the client is authorized is extended by the physician, Escort will notify ASNA the same day.
9. 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.
10. 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.

Escort’s Signature

Date: _____

Print Name

Date of Birth

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, _____, 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"/> Naqsrarmiut 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"/> Kuukpik 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"/> Aetna 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"/> 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: _____

****For Spouse****

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.

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Social Security Number: _____

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- | | | |
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| <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"/> Naqsrarmiut 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"/> Kuukpik Village Corporation | <input type="checkbox"/> City of Barrow | <input type="checkbox"/> Alaska Native Medical Center |
| <input type="checkbox"/> Tikiġaq 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"/> Aetna 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"/> Other Company _____ | | |

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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: _____