

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.

Critical Care/Life Decisions Assistance

If a physician is requesting family to be present to make life decisions for a 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.

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.
 - 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.

2022 ASNA Income Guidelines for MTFA

MTFA Income Guidelines 2023, Based on 2022 Federal and State Poverty Guidelines

Family Size	North Slope (Barrow)		North Slope (Villages)		Anchorage/Fairbanks		Out of State	
	2022 Federal Poverty Guidelines for Alaska	250% of Alaska Poverty Guideline	2022 Federal Poverty Guidelines for Alaska	300% of Alaska Poverty Guideline	2022 Federal Poverty Guidelines for Alaska	135% of Alaska Poverty Guideline	2022 Federal Poverty Guidelines for 48 contiguous states	120% of 2021 Federal Poverty Guideline for 48 Contiguous States
1	16,990	42,475	16,990	50,970	16,990	22,937	16,990	20,388
2	22,890	57,225	22,890	66,670	22,890	30,902	22,890	27,468
3	28,790	71,795	28,790	86,370	28,790	38,867	28,790	34,548
4	34,690	86,725	34,690	104,070	34,690	46,832	34,690	41,628
5	40,590	101,475	40,590	121,770	40,590	54,797	40,590	48,708
6	46,490	116,225	46,490	138,570	46,490	62,762	46,490	55,788
7	52,390	130,975	52,390	157,170	52,390	70,727	52,390	62,868
8	58,290	145,725	58,290	174,870	58,290	78,692	58,290	69,948

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

\$ 14,750

\$ 17,700

\$ 7,965

\$ 7,080

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

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 MTFA 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.

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.

Patient’s or Client’s Signature

Date: _____

Printed Name

Date of Birth

****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"/> Ijisaġvik 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"/> 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"/> 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"/> 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.

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"/> Ijisaġvik 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"/> Naqsragmiut 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"/> 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"/> 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: _____

OFFICE STAFF ONLY			
MTFA STAFF:		DATE:	
SPEAKING TO:			
NAME OF PATIENT:			

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	Alaska Airlines Mileage Number