

### **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.

## 2023 ASNA Income Guidelines for MTFA

MTFA Income Guidelines 2024, Based on 2023 Federal and State Poverty Guidelines

	North Slop	e (Barrow)	North Slop	e (Villages)	Anchorage	/Fairbanks	Out	of State
Family Size	2023 Federal Poverty Guidelines for Alaska	250% of Alaska Poverty Guideline	2023 Federal Poverty Guidelines for Alaska	300% of Alaska Poverty Guideline	2023 Federal Poverty Guidelines for Alaska	135% of Alaska Poverty Guideline	2023 Federal Poverty Guidelines for 48 contiguous states	120% of 2023 Federal Poverty Guideline for 48 Contiguous States
1	18,210	45,525	18,210	54,630	18,210	24,584	18,210	21,852
2	24,640	61,600	24,640	73,920	24,640	33,264	24,640	29,568
3	31,070	77,675	31,070	93,210	31,070	41,945	31,070	37,284
4	37,500	93,750	37,500	112,500	37,500	50,625	37,500	45,000
5	43,930	109,825	43,930	131,790	43,930	59,306	43,930	52,716
6	50,360	125,900	50,360	151,080	50,360	67,986	50,360	60,432
7	56,790	141,975	56,790	170,370	56,790	76,667	56,790	68,148
8	63,220	158,050	63,220	189,660	63,220	85,347	63,220	75,864

For families/households with more than 8 persons,add the following	North Slope (Utqiagvik)	North Slope (Villages)	Anchorage/Fairbanks	Lower 48 States
amount for each additional family member:	\$ 16,075	\$ 19,290	\$ 8,681	\$ 7,716

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.

Medical Assistance Application – FY2024v1 Page 1 of 7 Toll Free: 1 855-852-9114 Local (907) 852-9114 Fax Number: (907) 852-9152 P.O. Box 0029, Barrow, Alaska 99723 MTFA@arcticslope.org

OFFICE USE O	ONLY:					
ASRC	N	SB		Date Application	Received	
PI	lease print clearly an	d answer all	questions. Incom	olete applications wi	ll cause delay in proce	essing.
What type of	f assistance are you a	oplying for?	Medical Tra	avel Medic	al Housing	
	Middle Name, Last Na <b>ON ID or BIRTH CERT</b>		Gender	Date of Birth	Social Security Nur	nber
Physical Addr	ress or PO Box	- <u>-</u> City		State	Zip Code	
Applicant Pho	one Numbers Home:		Work:	Cell P	hone:	
Email:			Alask	a Airlines Mileage Nu	mber:	
-	ve been known by an at name(s):				Yes	☐ No
Are you a:	North Slope Boron Arctic Slope Regio Village Corporatio	nal Corporat n Shareholde	ion Shareholder? er?	collod.	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
	te the village tribal/c					
Name of Esco	ort (if one has been a	pprovea by y	our medical provid	der):		
	Middle Name, Last Na		Gender	Date of Birth	Cell Phone Numbe	r
,A3 3110 WW	ON ID OF BINTIFICENT	ii ica i z	Escort Alas	ka Airlines Mileage N	umber:	
Please list the	e location of your app	oointment, ti	me and date, and	name of case manage	er or doctor, if known:	
Please answe	<mark>er Yes or No:</mark> (Do not	leave blank.	)			
•	ou or your family hav				Yes	☐ No
	e of Insurance Compa s a work-related injur • If you answered	γ?	ou filed for worker	's compensation?	Yes Yes	☐ No

Anaktuvuk Pass	Atgasuk	Kaktovik	Nuiqsut	ARCTIC SLOP	E NATIVE AS:	ASOCIATION	Point Hope	Point Lay	Utqiaġvik	Wai	inwrigh
Do you hav Do you hav Do you hav Are you a U Do you owr • If so, I	e Medicaid e Medicare J.S. Veterar	Benefits: Benefits: Penefits: Penefits: Business	: Par	tA 🗌 P	art B				] Yes ] Yes ] Yes ] Yes ] Yes		No No No No No
(If you answe	ered yes, ple	ase submit	a Profit/L	Loss Statem	ent with t	his applic	cation)				
Do you own a home	e and recei	ve Rental	Income?						Yes		No

<u>Household Member Names & Income</u>: 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
Example: Jane Doe	00/00/00	000-00-000	Mother	\$ 000.00	Earned	Name of employer or source.

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.	

I certify that all the information provided on this application is true to the best of my knowledge. I understand I must

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.

Toll Free: 1 855-852-9114 Local (907) 852-9114

MTFA@arcticslope.org

# Patient or Client Agreement

This Agreement is entered into between (Client) 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 to share personal contact information with ASNA vendors for travel coordination purposes.
- 2. Client agrees not use alcohol or illegal drugs on an ASNA funded trip.
- 3. Client agrees to comply with all local laws and ordinances while on an ASNA funded trip.
- **4.** 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.
- 5. 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.
- **6.** Client agrees to allow only those individuals who are authorized by ASNA to stay in an ASNA-authorized room. <u>No other person, including children, may stay in the room</u>. Client agrees to obtain ASNA's authorization before allowing any person to stay in an ASNA authorized room.
- 7. 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.
- **8.** If a physician extends the treatment for which the Client is authorized, the Client agrees to notify ASNA the same day.
- 9. 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.
- 10. 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.
- **11.** Client understands and agrees that Client is responsible for any travel claims, including hotel and airline reservations, made prior to ASNA authorization.
- 12. 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.

	Date:	
Patient's or Client's Signature		

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

Date of Birth

**Print Name** 

# **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 <u>responsible adult</u> 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. <u>No other person</u>, <u>including children</u>, may stay in the room. Escort agrees to obtain ASNA's authorization <u>before</u> 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 Esco	rt acknowledges that he or she understands	s and agrees to the terms and conditions of this Agreer	nent.
		Date:	
Escort's Signature			
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.	I,, hereby request the disclosure of my financial information.						
Soc	cial Security Number:						
II.	The financial information is to be release	sed from: (Please check all employers	that apply)				
	North Slope Borough North Slope Borough School District Arctic Slope Regional Corporation Utqiagvik Iñupiat Corporation Atqasuk Iñupiat Corporation Kaktovik Iñupiat Corporation Kuukpik Village Corporation Tikigaq Corporation Cully Corporation Olgoonik Corporation Nunamiut Inupiat Corporation Native Village of Barrow Native Village of Atqasuk	Native Village of Nuiqsut Native Village of Point Hope Native Village of Point Lay Native Village of Kaktovik Naqsragmiut Tribal Council Wainwright Traditional Council City of Barrow City of Anaktuvuk Pass City of Atqasuk City of Kaktovik City of Nuiqsut City of Point Hope City of Point Lay	City of Wainwright  SKW Eskimos Inc.  Ilisagvik College  ICAS  Arctic Slope Consulting Group  Samuel Simmonds Memorial  Alaska Native Medical Center  Maniilaq Health Center  Medicaid  PacifiCare Insurance  Aetna Insurance  State of Alaska  ASNA, Ltd.				
III.	•	uthorization has not been revoked, it v	to the extent that action has been taken will terminate one year from the date of MTFA program services.				
Sig	nature:		Date:				
IV.	PLEASE DO NOT  The Information to be released is for in  Please state the 12 months total inc		ICE USE ONLY)				
	<ul> <li>Total gross income for the last 12 m</li> </ul>	onths:	\$				
If n	o longer employed, please share date o	f departure/termination:					

Fax Number: (907) 852-9152

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I. I,information.		, hereby reque	est the disclosure of my financial				
Social Security Nur	mber:						
II. The financial i	nformation is to be release	d from: (Please check all employe	rs that apply)				
_	rough School District gional Corporation at Corporation t Corporation t Corporation Corporation ation on oration iat Corporation	Native Village of Nuiqsut Native Village of Point Hope Native Village of Point Lay Native Village of Kaktovik Naqsragmiut Tribal Council Wainwright Traditional Council City of Barrow City of Anaktuvuk Pass City of Atqasuk City of Kaktovik City of Nuiqsut City of Point Hope City of Point Lay	City of Wainwright  SKW Eskimos Inc.  Ilisagvik College  ICAS  Arctic Slope Consulting Group  Samuel Simmonds Memorial  Alaska Native Medical Center  Maniilaq Health Center  Medicaid  PacifiCare Insurance  Aetna Insurance  State of Alaska  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 emplo	oyed, please share date of o	leparture/termination:		_			

Fax Number: (907) 852-9152