

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. **NOTE: ASNA’s ability to provide financial assistance is subject to availability of funds. In the event of a shortfall, ASNA will discontinue accepting applications and authorizing benefits.**

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.
5. Medical travel assistance is only available to an applicant whose medical condition requires scheduled, immediate, or ongoing treatment unavailable in the community in which the applicant is a resident.

2027 MTFA Income Guidelines, Based on 2026 Federal and State Poverty Guidelines

Family Size	2026 Federal & State Poverty Guidelines	Utqiagvik	North Slope Villages	Anchorage & Fairbanks	Lower 48 States
		250% of Alaska Poverty Guideline	300% of Alaska Poverty Guideline	135% of Alaska Poverty Guideline	120% of Federal Poverty Guideline
1	\$19,950	\$49,875	\$59,850	\$26,933	\$23,940
2	\$27,050	\$67,625	\$81,150	\$36,518	\$32,460
3	\$34,150	\$85,375	\$102,450	\$46,103	\$40,980
4	\$41,250	\$103,125	\$123,750	\$55,688	\$49,500
5	\$48,350	\$120,875	\$145,050	\$65,273	\$58,020
6	\$55,450	\$138,625	\$166,350	\$74,858	\$66,540
7	\$62,550	\$156,375	\$187,650	\$84,443	\$75,060
8	\$69,650	\$174,125	\$208,950	\$94,028	\$83,580

For families/households with more than 8 persons, add the following amount for each additional family member: \$7,100

Utqiagvik	North Slope Villages	Anchorage & Fairbanks	Lower 48
\$17,750	\$21,300	\$9,585	\$8,520

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.

OFFICE USE ONLY: ASRC _____	NSB _____	Date Application Received _____
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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: _____ Cell Phone: _____

Email: _____ Alaska Airlines Mileage Number: _____

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)

Escort Alaska Airlines Mileage Number: _____

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 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.

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 or be in the possession of these items on an ASNA funded trip.
3. Client agrees to comply with all local laws and ordinances, including hotel/housing policies 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. No other person, including children, may stay in the room. 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.

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: _____

 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: (Check only the entities that provide your payroll or honorariums)

- | | | |
|--|---|--|
| <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"/> Iñisaġvik 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"/> Naqsraġmiut 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.

I, _____, hereby request the disclosure of my financial information.

Social Security Number: _____

II. The financial information is to be released from: (Check only the entities that provide your payroll or honorariums)

- | | | |
|--|---|--|
| <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"/> Naqsrāġmiut 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"/> Tikigāq 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: _____