



Arctic Slope Native Association

Anaktuvuk Pass • Atkasuk • Barrow • Kaktovik • Nuiqsut • Point Hope • Point Lay • Wainwright

Critical Care & Funeral Assistance 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 decedent or 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.
4. ASNA is the LAST source of assistance. This means all other resources have been exhausted.

ASNA Income Guidelines for MTFA

2012 Income Guidelines Effective June 2, 2010

Family Size	North Slope (Barrow)		Anchorage/Fairbanks		Out of State	
	2010 Alaska Poverty Guideline	200% of Alaska Poverty Guideline	2010 Alaska Poverty Guideline	135% of Alaska Poverty Guideline	2010 Allstate's Poverty Guideline	120% of 2010 Allstate's Poverty Guideline
1	13,530	27,060	13,530	18,266	10,830	12,996
2	18,210	36,420	18,210	24,584	14,570	17,484
3	22,890	45,780	22,890	30,902	18,310	21,972
4	27,570	55,140	27,570	37,220	22,050	26,460
5	32,250	64,500	32,250	43,538	25,790	30,948
6	36,930	73,860	36,930	49,856	29,530	35,436
7	41,610	83,220	41,610	56,176	33,270	39,924
8	46,290	92,580	46,290	62,492	37,010	44,412

Each Additional Family Member Add:	<u>North Slope Area</u> \$ 9,360	<u>Anchorage/Fairbanks</u> \$ 6,316	<u>Lower 48 States</u> \$ 4,488
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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.

MTFA Critical Care and Funeral Assistance Program Information

Funeral Benefit Coordination

It is expected that the immediate family of the decedent will select one individual to serve as the contact person for coordination between the family and ASNA MTFA staff for funeral expense and travel benefits.

Funeral Expense Assistance

1. The maximum total assistance provided for funeral expense is up to \$2,000.00. This is separate from any funeral travel costs. The funeral benefit may assist with the cost of the casket, shipping of casket, and funeral home expense.
2. Any funeral expense in excess of the \$2,000.00 limit shall be the responsibility of the family/applicant.

Funeral Travel Assistance

1. Funeral travel assistance will purchase up to two (2) in-state tickets and one (1) out of state ticket.
2. Every family member requesting a ticket must apply separately and meet the income guidelines to receive assistance.

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.

What type of assistance are you applying for?

Funeral Expenses

Funeral Travel

Critical Care Travel

First Name, Middle Name, Last Name

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 another 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: _____

Information Regarding the Deceased Family Member

Name of decedent: _____

Relationship of decedent: _____

Date of Death: _____

Is the decedent a U.S. Veteran? Yes No Post: _____

Is the decedent a North Slope Resident? Yes No

ASRC Shareholder Yes No

Describe your situation and what you need from ASNA. _____

Earned Income: Please list all employers of the adult(s) in the household who have worked within the last 12 months. In addition, include honorariums and loss of pay received from public service(s).

Note: Even if you are not currently working, we still need to verify all income earned within the past 12 months.

Unearned Income: Please list the source(s) and amounts of all unearned income received by the household in the past 12 months. (Child Support/Welfare Payments, State Adult Public Assistance, Unemployment Benefits, Disability, Social Security Income, and any other income received from other sources.)

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

Names of Everyone in Household: Please list the names of all individuals who are living in your household, including any children or dependents age 18 or under:

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 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.

Funeral Assistance Resources Sheet

This form provides ASNA MTFA staff with a list of resources that will be provided to the family for funeral assistance. By providing the requested information, you will allow our staff to better assist with coordination of the funeral.

Vendors	Invoice Total	ASNA	Public Assistance	Native Corporation	Tribal Affiliation	Other	Other	Remaining Balance
Total	\$	\$	\$	\$	\$	\$	\$	\$

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: _____

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"/> Iĭisaĭvik 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: _____