KUUKPIKMIUT FOUNDATION

P.O. Box 89187
Nuiqsut, Alaska 99789-0187
TEL: (907) 480-6220
or 1 (888) 480-6220
FAX: (907) 480-6126

MEDICAL TRAVEL ASSISTANCE APPLICATION

LAST NAME **FIRST NAME** **MIDDLE NAME**

ADDRESS **NUMBER** **STREET** **CITY** **STATE** **ZIP**

TELEPHONE NUMBER(S)

Are you a ____ Nuiqsut resident ____ Kuukpik shareholder ____ Descendent of Kuukpik?

Please check the item of assistance you are applying for:

_____ Travel / _________ Amount _______ Housing / _________ Amount ______ Meals ______ Days

Please explain your situation and describe the assistance you need:

____
____
____
____
____

Do you or anyone in your household have medical insurance? ______ Yes ______ No

If so, name of insurance company: ______________________________

Is this a work related injury? ______ If so, have you filed for workman's comp? __________

Do you have Denali Kid Care? ______ Do you have Medicaid? ______ Medicare? ______

Please list the number and names of all adults in the household:

Name	Date of Birth	SS#	Relationship to You

Please state the number of children under the age of 18 living in the household ______

Are any of the adults in the household financially assisting you in this travel? ______

Earned Income: Please provide us the names of adults and the companies they have worked for in the past 12 months…please provide all info for the past 12 months.

Name of Employee	Date of Birth	Date of Employment	Total Income

Do you have a personal business? __________ Rental income? __________

Unearned income: Please provide us names in the household that earn monthly income in terms of honorariums, perdiems or any other related unearned income to the household.

Name	Company earning income from	Amount per month

Please provide us with names of household members who receive Kuukpik dividends as well as State of Alaska Permanent Fund dividends.

Names

Do you have any other means of getting financial assistance? __________

Have you applied for the ASNA assistance program? __________ If so, were you denied? __________

Please state reason(s) ____

____

Has the Foundation assisted you in the past 12 months? __________Yes __________No

If this appointment or assistance is non emergency, non life threatening but the committee felt that your appointment or reason of travel is important, and if a waiver to assist you was approved, would you consider paying back the Foundation for expenses that are not in the regular procedure of medical assistance? __________Yes __________No Do you have the means to pay the Foundation back for all expenses? __________Yes __________No

What other information should the committee know in assisting you in processing your application for assistance:

____

____

____

I certify that all the information I have provided is true to the best of my knowledge. I understand that if I pass on false information I may be denied for assistance up to two years. I also understand that I must cooperate with providing information so that all facts are available.

____________________________ ____________________________

Applicant's Signature Witness Signature

Date: ____________________