KUUKPIKMIUT FOUNDATION

Medical Travel Assistance Application

Relates to:

- ☐ Nuiqsut Resident
- ☐ Kuukpik Shareholder
- ☐ Descendent of Kuukpik Shareholder

Patient Name: ________________________________

Address: ________________________________

________________________________ Phone: ________________

Please explain your situation and describe the assistant you need:

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

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? ________________

List all the number and names of all adults in the household			
Name	Date of Birth	Social Security #	Relationship

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: Provide the names of adults and the companies they have worked for in the past 12 months (provide all info for the past 12 months)			
Name of Employee	Name of Employer	Dates of Employment	Total Income

Do you have a Personal Business? ______________________ Rental Income? ______________

Un-earned Income: Provide the names in the household that earns monthly income in terms of honorariums, per diems or any other related unearned income to the household			
Name	Company	Earning Income	Amount Per Month

Provide the names of household members who receives Kuukpik Dividends, as well as State of Alaska Permanent Fund Dividends:	

Has the Foundation assisted you in the past 12 months ☐ Yes ☐ No

If so please write dates and length of assistance to date. ☐ Yes ☐ No

Is there other information should the committee know in assisting you in processing you application for assistance?____

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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 DENIED FOR ASSISTANCE UP TO TWO YEARS, I ALSO UNDERSTAND THAT I MUST COORPERATE WITH PROVIDING INFORMATION SO THAT ALL FACTS ARE AVAILABLE AND WILL FOLLOW THE PROCEDURES AND POLICIES OF THE FOUNDATION PERTAINING TO THE ASSISTANCE PROGRAM.

______________________________ ______________________________

Applicants Signature Witness Signature

____________________ ____________________

Date Date

Office Use Only/ Received By:	Date: