Kikiktagruk Inupiat Corporation

Medical Assistance Request Form

The KIC Board of Directors authorizes the following policy for the distribution of Medical Assistance. This program may be approved by the President & CEO, or their designee. Any requests that fall outside of this policy will be forwarded to the Board of Directors for consideration at the next scheduled Regular Board Meeting.

Eligibility Criteria

- Must involve emergencies, life-threatening situations, or situations that involve extensive treatment for life-threatening diseases.
- Scheduled or routine medical appointments are not eligible for assistance as emergency life-threatening events.

Eligible Recipients

- KIC Shareholders, Descendants of KIC Shareholders, and Legal Spouses of KIC Shareholders

Benefit Guidelines

- Assistance may be authorized up to $500 per request, based on available funding
- Assistance is limited to one request per individual per calendar year for an emergency or up to four times per year for an individual undergoing extensive treatment for a life-threatening disease.
- Assistance is for traveling for critical resources that cannot be medically covered in the home community
- Payment issued to the patient or next of kin

Patient Information

First & Last Name _____

Date of Birth _____Social Security Number _____

Patient is (select one):

☐ KIC Shareholder ☐ KIC Shareholder lineal or direct descendant ☐ KIC Shareholders Spouse

If Shareholder lineal or direct descendant or spouse, please provide original shareholders information:

First & Last Name _____

Date of Birth _____Social Security Number _____

Applicant / Payee Information

First & Last Name _____

Relationship to Patient _____ Phone Number _____

Mailing Address_____

E-mail Address_____

Signature_____ Date _____

Medical Information

Attending Physician First & Last Name _____

Medical Facility_____Phone Number _____

*Attach documentation from medical facility verifying medivac transport or a statement of eligibility with supporting documentation.

Payment Processing Option (Choose One)

☐ Direct Deposit ☐ Mail ☐ Check Pick up Location (Select One) ☐ Kotzebue ☐ Anchorage

Mailing Information (If different from Applicant/ Payee Information on Page 1)

First & Last Name _____

Relationship to Patient _____ Phone Number _____

Mailing Address_____

E-mail Address_____

Signature_____ Date _____

Direct Deposit Information

Bank Name _____Account Type _____

Routing Number_____Full Account Number _____

Payee Name _____Phone Number_____

E-mail Address_____

Signature_____ Date _____

KIC INTERNAL USE ONLY

Approved _____ Denied _____

Amount Approved _____

Date Received Request_____Date sent to Accounting _____