NATIVE VILLAGE OF KOTZEBUE
KOTZEBUE IRA

Medical Assistance Program
P.O. Box 296
Kotzebue, Alaska 99752
907.442.3467 - Phone 907.442.4013 – Fax Line

MEDICAL ASSISTANCE APPLICATION

The Native Village of Kotzebue may/can provide limited food assistance in medical emergencies for tribal members who leave Kotzebue for extended medical treatment as ordered by the hospital or clinic in Kotzebue. The assistance will only be provided **once a year per patient.**

To **pre-qualify** for this assistance, the following situation must exist:

1. The patient must be a **tribal member** of the **Native Village of Kotzebue** (and have updated/current information on file with tribal enrollment specialist).
2. The request will be required to be made two (2) weeks in advance unless it is a medi-vac emergency.
3. The patient must provide a written form from their doctor or certified health care provider.
4. The patient is required to be away from home for a minimum of **one (1) week or longer** by orders from a doctor or certified health care provider.
5. It is the patient/escort responsibility to follow up on the required paperwork before a voucher/check is issued.

Once **qualified**:

1. The medical assistance will be in the form of a voucher or check made out to the patient or in the case of a minor to either the parent and/or escort who will be following the child out of town for medical attention.
2. **Only food items** essential for your prolonged stay can be purchased.
3. **Not allowed** are the following
    a. no cigarettes
    b. tobacco products
    c. candy
    d. soda pop
    e. energy drinks
    f. chips
    g. or any non-food items

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This form certifies that _____, DOB_____ is required to be away from Kotzebue for a **week or more** for medical treatment or appointments. Approximate dates, from_____ to _____.

Patients Name: _____
Address: _____
_____
Phone Number: _____

Destination City: _____
Phone Number: _____
Message Number: _____
Escort or Guardian: _____

_____
(Printed name of Health Care Provider)

_____ _____
(Signature of Health Care Provider) (Signature of Patient, Parent and/or Escort)

_____ _____
(Medical Affiliation/Facility/Organization) (Date)

_____
(Date)