



EMERGENCY HEALTHCARE FINANCIAL SUPPORT APPLICATION

THIS EMERGENCY HEALTHCARE FINANCIAL SUPPORT APPLICATION IS FOR UNFORESEEN EMERGENCY MEDICAL EXPENSES ONLY. REGULAR SCHEDULED MEDICAL APPOINTMENTS ARE NOT FUNDED BY THIS PROGRAM.

A. PATIENT INFORMATION (Provide contact information of patient being funded. If you are not the patient then you need to fill out the PATIENT ESCORT INFORMATION in Section B of this application.)

Form fields for Patient Information: Patient Name (Last, First, MI), Patient Birthdate, Patient Mailing Address, City, State, ZIP, Primary Phone #, Alternate Phone #, Email

B. PATIENT ESCORT INFORMATION

Form fields for Patient Escort Information: Escort Name (Last, First, MI), Escort Birthdate, Escort Mailing Address, City, State, ZIP, Primary Phone #, Alternate Phone #, Email

Are you submitting this application on behalf of the Named Patient? Yes No

Are you directly related (mother, father, sister, brother, son or daughter) to a current board member of the Tebughna Foundation? (Not Tyonek Native Corporation board members)

Yes No (if "Yes" please provide their name & relationship) Name: _____ Relationship: _____

C. PATIENT MEDICAL NEEDS (Please describe the circumstances of the patient's medical needs or attach a signed doctor's note describing the patient medical situation.)

Blank lines for describing patient medical needs.

Is the patient expected to be admitted for an extended period of time at a medical facility? Yes No Unsure

Will the patient require an escort for the duration of their medical treatment?..... Yes No Unsure

D. AUTHORIZATION

By signing this Application, I acknowledge that I have read and agree to the guidelines and terms specified below:

- 1. I certify that the information on this application and its supporting documents is accurate and complete to the best of my knowledge. I understand and agree that failure to fully complete the form, or misrepresentation or omission of facts, represents grounds for elimination from consideration for funding.
2. I certify that the document has been duly authorized by the governing body of the applicant, and that the applicant will comply with any assurances, requirements, and stipulations set by Tebughna Foundation if assistance is awarded.

SIGNATURE OF APPLICANT: _____ DATE: _____

OFFICIAL USE ONLY

Date Received: _____ Funding Approval? Approve Deny Amount Approved: \$ _____