Tebughna Foundation
Perserve, Enhance, Educate, & Serve

Medical Fund Application

A. PATIENT INFORMATION

Full Name (Last, First, MI) _____

Date of when you received medical treatment _____

Hospital/clinic where you received medical treatment _____

City _____ State _____ ZIP _____

Are you a: ☐ TNC shareholder ☐ NVT tribal member

B. MEDICAL COST INFORMATION

Food, lodging, or transportation costs incurred by the patient or their family during medical treatment are eligible to be funded by Tebughna Foundation. Tebughna Foundation will reimburse up to $1000 for medical costs not covered by IHS, Medicaid, insurance, or other entity.

EXPENSES	
EXPENSE	AMOUNT
	$
	$
	$
	$
TOTAL EXPENSES:	$

Are you able to provide documentation of your hospital stay? (bills, receipts, etc.) ☐ Yes ☐ No

If no, explain: _____

_____

C. COMMENTS *(Please summarize your needs below.)*

_____

_____

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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.
3. I give the Tebughna Foundation permission to release, as appropriate, my comments, photos, names, and event details for Tebughna Foundation Publications.

SIGNATURE OF APPLICANT:_____ **DATE**:_____

SUBMIT THIS APPLICATION AND ALL APPLICABLE DOCUMENTS TO:

Tebughna Foundation
1689 C Street, Suite 120
Anchorage, Alaska 99501
info@tebughnafoundation.com
(907) 646-3115

OFFICAL USE ONLY

REMARKS:

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

Check #:_____ Check Payable To:_____ Authorized By *(Initial)*:_____