



NORTHWEST ARCTIC BOROUGH MEDICAL ASSISTANCE



Cancer Screen/Treatment
 Medivac
 Elder

Patient Name: Date:

Patient Date of Birth:

Escort Name:

Address:

Phone Number: Message:

Check Payable to:

- | | | |
|---|------------------------------|-----------------------------|
| Is the patient a Borough Resident? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is Travel covered? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are Meals covered? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is Housing covered? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient have Health Insurance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient have Denali Kid Care? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient have Medicaid? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the Patient on Public Assistance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PLEASE ATTACH COPY OF MEDICAL APPOINTMENTS/COVERAGE, failure to attach document may result in denying assistance.

PLEASE NOTE THAT CHECKS WILL HAVE TO BE PICKED UP AT THE BOROUGH OFFICES IN KOTZEBUE, NO EXCEPTIONS.

Revised 1/18/2012

