EMERGENCY MEDICAL ASSISTANCE APPLICATION

GTB tribal members are eligible to receive up to $500 in emergency medical assistance per year in documented (appointment card, physician’s note, etc.) life threatening medical situations involving their spouse or child (19 years old or younger). Non-employee travel rates will be used and receipts will be required for all allowable expenses which include: motel stay, mileage and meal allowance. Reimbursement for expenses is allowable if preplanning in not an option as long as original receipts are submitted. All other possible resources must be exhausted. There are no income guidelines for this assistance.

Name: ____________________________________________________ Date: __________________________

Phone: ____________________________________________________ TID: __________________________

Purpose of Travel – brief reason of Medical Emergency, travel destination, number of people traveling and estimated length of stay:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

ESTIMATED TRAVEL COSTS

Gas
Total number of gas fill ups _________ x $30 each Amount: $_______________

Lodging - Standard rate of $50 per night
Total number of Nights ___________ x $50 per night Amount: $_______________

Meals – Standard rate of $6.50 per meal, $19.50 per day
Total number of Meals ___________ x $6.50 per meal Amount: $_______________
* only allowable for GTB patient/parent/spouse

TOTAL: $_______________

I agree to repay this emergency assistance in the event that proper documentation is not submitted regarding costs incurred during the period of travel. I understand that this assistance is for the sole purpose of providing for unplanned travel expenses outside of the six county service area incurred due to emergency medical treatment of myself or my immediate family member.

Signature: _____________________ Date: ______________________________

Required Documentation to be attached:

☐ Proof of Residency ☐ Tribal ID ☐ Doctors Appointment Notice