NATIVE VILLAGE OF BARROW

IÑUPIAT TRADITIONAL GOVERNMENT

2026 ARPA Short Term Program

Medical Assistance Application

ARPA Application Checkout List

The following items MUST be completed and verified prior to submitting your application:

1. **Physical Address:**
☐ **I have provided my physical address.**

2. **Mailing Address:**
☐ **I have provided a PO Box or mailing address.**

3. **W9 Form:**
☐ **I have completed the W9 form with the mailing address where the check will be sent.**

4. **Check Preference:**
I would like my check:
☐ **Mailed to my provided address**
☐ **Picked up in person**

5. **Document Verification:**
☐ **I have verified that all required documents are included.**
☐ **I have marked the list on the application to confirm my documentation is correct.**

6. **Current Phone Number:**
☐ **I have provided a current contact phone number.**

Submission Information:
Please submit the application in person at the **Native Village of Barrow main office or email it to **ARPA.application@nvb-nsn.gov**.**

Important Reminder:
All boxes must be checked on the document checklist of the application and the ARPA checklist to avoid automatic rejection; applications will be automatically rejected if all documents are not submitted with your application. Please note that it may take up to 15 business days to process the application from beginning to end, ARPA will contact you once the check is ready. By signing you are certifying that the application is completed with all documents and correct information.

Member Signature: _____
Date: _____

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2026 ARPA Short Term Program

Medical Assistance Application

Medical assistance may be granted to Native Village of Barrow tribal members under the ARPA program in accordance with the policy. The assistance is for current medical situations and cannot be retroactive. Tribal members may qualify for assistance if they must travel out of the local area for further medical care, which may include a medical travel escort. Medical travel escorts must fill out a separate application and provide all documentation if they wish to apply. Please provide a copy of your identification and medical note.

Applicant Information

Applicant Name: _____ Today's Date: _____

D.O.B: _____ Tribal Enrollment # : _____ SSN: _____

Phone Number: _____ Email Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Financial Hardship Declaration

Have you experienced financial hardships associated with the COVID-19 pandemic? **Yes** ☐ **No** ☐

Briefly describe your situation below: ***Do not release sensitive medical details.***

_____

_____

_____

_____

Medical Travel Support [ARPA – SLFRF category 2.3 Household assistance – cash transfer]

A. **Eligibility and preferences –** Native Village of Barrow tribal members without an age limit.
B. **Application Process –** Medical assistance is in place for specialties that are of health required by the provider and the member must seek it outside of their local area. Native Village of Barrow tribal members must fill out an application and attach a letter from their primary care provider or case management. *Assistance may not be used for dental cleaning or yearly medical physical exams.* Medical escorts may qualify if they are a tribal member, applying as an escort will not count against that member's one-time travel support. Members with long-term or permanent medical conditions may be eligible to apply more than once per calendar year, up to twice per month with a copy of their doctor's note. *The note must be from the provider on the provider's letterhead stating that the patient requires further medical care outside of the local area*. Parents who need to escort their children for major emergencies may qualify as an escort (per child) during the period of one year.

C. Please note that the attached medical letter for the application may not be the itinerary of travel, appointment email, or reminder. The administration staff has the right to deny the approval of medical assistance if the proper documentation is not presented.

D. **Limited Funding:** The program has a set amount of funding available.

E. **First Come, First Serve:** Applications will be processed in the order they are received.

F. **Program Closure:** Once funding runs out, no further applications will be accepted, and the program will cease until further funding is obtained.

G. **Application Approval:** Applying does not guarantee approval; if funding is exhausted, applications will be denied.

H. **Typical award and individual award limits –** $500 per individual, maximum allowance may not exceed one-time assistance within the qualifying year unless allowed per the policy guidelines.

I. **Policy may be subjected to change in accordance with this grant's federal policies.**

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Acknowledgements & Attestation

I understand I do not qualify if medical assistance was already granted previously in the same year, unless I meet the requirements as stated in the medical assistance policy above.

I understand that providing false information, acquiring federal funding with false pretense or not notifying the Native Village of Barrow of significant changes to my application are grounds for denial of any assistance and/or civil and criminal prosecution that may be conducted by the Native Village of Barrow.

I confirm that I have read the medical assistance policy above and understand that the Native Village of Barrow has the right to deny applications per the policy and guidelines.

I hereby certify that all information and documentation provided in this application are true and accurate.

By signing below, the applicant allows the Native Village of Barrow to verify the information provided, or request more information, to participate in the ARPA Short-Term Program for Medical Assistance.

_____ _____

Applicant Signature **Date**

_____

Applicant Printed Name

Checklist

It is the responsibility of the applicant to provide all documentation listed below.

- ☐ Copy of government-issued I.D.
- ☐ Note from Case management or MD per above policy.
- ☐ For long-term medical assistance, doctor's note stating the long-term need of travel out of the local area due to the permanent or long-term condition (This must be from the MD and will be required to update every six months)
- ☐ W-9 form

NATIVE VILLAGE OF BARROW OFFICIAL USE ONLY

_____ _____
Receiving Staff Signature **Date**

_____
Receiving Staff Printed Name

Approved: ☐ Yes ☐ No **Denial Communicated**: ☐ Yes ☐ No

_____
ARPA Manager

Reason: _____

NATIVE VILLAGE OF BARROW
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2026 ARPA Short Term Program

Medical Travel Necessity Certification Form

Date: _____

Patient's name: _____

DOB: _____

Travel location from: _____ to _____

Statement of necessity:

I certify that the above patient requires to travel outside of the local area for special appointment, treatment, specialty clinic, surgery or rehabilitation. The travel is necessary as the medical need cannot be provided at _____, which requires for us to refer the patient to _____ medical facility.

Please state if the following apply:

- ☐ **The patient has a long-term (illness or sickness that latest further than a year) or permanent.**

If so, please state if this will cause the patient to travel several times a year and for how long?

_____

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Does the patient require an escort?

Yes

No

If yes, please provide the escort's name:

I certify this statement is correct,

Provider's name: _____

Attending Facility: _____

Signature: _____

Date: _____

Medical assistance is in place for specialties that are of health required by the provider and the member must seek it outside of their local area. Native Village of Barrow tribal members must fill out an application and attach a letter from their primary care provider. *Assistance may not be used for dental cleaning or yearly medical physical exams.* Medical escorts may qualify if they are a tribal member, applying as an escort will not count against that member's one-time travel support. Members with long-term or permanent medical conditions may be eligible to apply more than once per calendar year, up to twice per month.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they