Bois Forte Health & Human Services

Medical Emergency Fund Guidelines

What is the Bois Forte Medical Emergency Fund?

The Bois Forte Medical Emergency fund was established by the Bois Forte Reservation Tribal Council to travel to care for or visit an immediate family member with a serious health condition that arises in emergency circumstances. Other instances where the fund may be accessed is a medically necessary surgery or one post-operation visit.

Eligibility

1) The medical situation must be emergent as defined below, a medically necessary surgery, or a post-operation follow-up appointment
2) Must be 18 years or older to apply for assistance
3) The patient or applicant must be a Bois Forte Band member
4) The patient or the applicant must be a resident of one of the following counties: St. Louis, Koochiching, Itasca
5) The applicant must have to travel greater than 45 miles from home to the healthcare facility
    a. Exceptions to this rule include patients in the metropolitan area and/or;
    b. Patients who require an overnight stay

Requirements

1) Application must be filled out
2) Verification of admittance from the facility the patient is located.
    a. Verification must include short reason for stay, length of stay, signature, letterhead
    b. This is the patient/family's responsibility. The MEF worker will not request this on behalf of the patient.
3) Tribal enrollment verification
4) If the trip is not made, all money received must be returned to Bois Forte within 10 days of check date
5) The check issued needs to be picked up within 10 days from the date of the check. If not, the check will be voided.
6) If someone else is going to be receiving the check, it needs to be stated on the application.
    a. All changes to this need to be received in writing. Verbal notification will not be accepted.
    b. Checks are printed and distributed at the Bois Forte Reservation Government Building in Nett Lake.
    c. If not stated on the application that the check is going to be picked up, the check may be mailed to address listed on the application.
7) All requests for same day services needs to be turned in to the MEF worker by **2:00 pm**. Those not received on time may not receive their check that day.

Limitations

1) A max of $400.00 in assistance will be given per patient per calendar year
    a. 21¢ per mile traveled
    b. $70.00 per night lodging
    c. $40.00 per day for meals

Definitions

Medical Emergency: an acute injury or illness that poses an immediate risk to a person's life or long-term health, sometimes referred to as a situation risking "life or limb"

Immediate Family Member: Spouse, Significant other, child, parent, stepchildren, foster children, grandparents, grandchildren

Contact Information

Bois Forte Health & Human Services
Attention: Medical Emergency Fund
5219 St. John Drive
Nett Lake, MN 55772
Telephone: (218)757-3650
Fax: (218)757-0222

Bois Forte Enrollment Office
Attention: Enrollment Coordinator
5344 Lakeshore Drive
Nett Lake, MN 55772
Telephone: (218)757-3261 opt. 1
Fax: (218)757-3312

Bois Forte Health & Human Services

Medical Emergency Application

Applicant Name:		Relationship to Patient:
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Bois Forte Enrollment Number: **404A**	Who's enrollment number is this? Applicant Patient	
Name of Patient with Medical Emergency:		
Name of Facility:		
Address:		
City: State:	ZIP Code:	Phone:
How will the check be received? Mail Pickup	**If the check is being picked up, by who?**	
Has the patient received assistance from this program in the past?	Yes No	If yes, when?

Please list the expenses you feel that you may need assistance

Lodging at:		**for**		Nights at **$70.00** per night	$
Round trip mileage from:		**to**		miles X **.21¢** per mile	$
		Meals for:		**days** at **$40.00** per day =	$
				Total expenses (not to exceed $400):	$

Office Notes:

- *I **CERTIFY** that I have no other income or resources to meet this need.*
- *I **AGREE** that Bois Forte Health Services may make such inquiries that are necessary to verify the information that I have provided.*
- *I **AUTHORIZE** any person or entity to disclose information about me to Bois Forte Health Services for the purpose of determining my eligibility.*
- *I **UNDERSTAND** that if I make false statements on my application that I am subject to criminal prosecution under Section **615.02 FALSE CLAIMS** of the Bois Forte Criminal Code.*
- *I **UNDERSTAND** that if for any reason I do not use the funds for the purpose requested, I will be required to return the funds to Bois Forte within 10 days. If I fail to do so, I agree that the amount may be deducted from any per capita payments payable to me.*

Signature of applicant:	***Date:***

For office use only

Application received:	***Enrollment Verification Received:***	***Facility Verification Received:***	***Date of Check:***