Pokégnek Bodéwadmik
POKAGON BAND OF POTAWATOMI
ELDER'S COUNCIL

POKAGON BAND OF POTAWATOMI INDIANS
ELDER MEDICAL REIMBURSEMENT PROGRAM

APPLICATION

- Completed Applications must be delivered in person, by U.S. Mail, by email, or by fax. If delivered **in person**, the completed Application must be delivered to the Elders Specialist at Elders Hall, 53237 Townhall Road, Dowagiac, MI 49047, or **by mail** to the Elders Specialist, P.O. Box 180, Dowagiac, MI 49047, or **by Email** to **Beth.Warner@pokagonband-nsn.gov**, or **by Fax** to (269) 782-1696.
- The Elder Medical Reimbursement Program is governed by the Elder Medical Reimbursement Program Policy ("Policy"), copies of which are available at Elders Hall or on the Band's website.
- Elder Medical Reimbursement Program is limited to $300 of Medical Reimbursement Assistance per Elder for certain medical and health care expenses incurred by an Elder for the Elder during a calendar year, it is subject to available funding and will be awarded on a first-come, first-served basis.
- Medical Reimbursement Assistance will be paid to the Elder and not to any other person or entity.
- If you have questions or need assistance with this Application, please contact the Elders Specialist at (269) 782-0765.

Name: _____ Date: _____

Telephone Number: _____ Date of Birth: _____

Band Enrollment Number: _____

Physical Address: _____

Mailing Address (if different): _____

Email: _____ Fax: _____

Please check the boxes below that describe which medical expenses you have incurred and you are seeking reimbursement for <u>and include all required supporting documentation</u>.

Section 3(a) - Medical and healthcare services, supplies and equipment incurred by the Elder for the Elder	Includes but is not limited to the following: ☐ medical provider consultations or treatments ☐ in-home medical care services ☐ medication ☐ prescriptions ☐ medical alert systems and devices ☐ orthotics ☐ prosthetics ☐ Other: _____

State the date(s) that you incurred these expenses: _____

State the amount of Medical Reimbursement Assistance requested: $_____

Have you attached all receipts, invoices, and other documentation to this application?

Yes ☐ No ☐

During the current calendar year (January 1st – December 31st), have you **<u>received</u>** any assistance for this need under this or any other assistance programs?

Yes ☐ No ☐

If yes, please identify:

Program Name: _____

Date of Assistance: _____

Amount of Assistance: _____

Reason for the Assistance: _____

By signature below, the Applicant acknowledges and agrees that:

- This Program is structured with the intent that the Medical Reimbursement Assistance be non-taxable to Elders under the Tribal General Welfare Exclusion Act and IRS Revenue Procedure 2014-35 and not subject to information reporting and withholding

under federal tax laws and regulations. Nonetheless, if Internal Revenue Service deems the Medical Reimbursement Assistance, or any portion of the Medical Reimbursement Assistance, to be taxable, then the Elder (and not the Band) shall be solely responsible for any taxes, interest and penalties owed from receipt of the Medical Reimbursement Assistance. Elders are encouraged to contact a tax advisor with any tax questions relating to the Medical Reimbursement Assistance.

- The Band shall not be responsible for any conditions, warranty, performance, or other issues, including any malfunctions, losses, damages (including personal injury, death, or damage to any property), etc., arising from or in any way related to any Medical Reimbursement Assistance. To the fullest extent permitted by applicable law, by participating in the Program, an Elder shall be deemed to have forever released, waived, and agreed not to sue the Band and its officials and employees from all claims, damages, liabilities, and expenses, which arise, directly or indirectly, in connection with participating in the Program.

- The Applicant has fully read the Policy and this Application.

The Applicant hereby certifies that the above information is true, complete, and correct in all respects.

_____ **Date:** _____

Applicant's Signature

FOR ELDERS SPECIALISTS USE ONLY

Date the Application was received by Elders Specialist _____.

Method the Application was delivered_____

On _____ the Elders Specialist determined that this Application:

☐ **Does comply with the requirements of the Policy and is otherwise complete. The Application was approved and reimbursement was requested on _____.**

☐ **Does not comply with the requirements of the Policy, or that the application is not otherwise complete. The Elders Specialist informed the Applicant of this determination ☐ in writing, ☐ electronically or ☐ orally on: _____. The reason for determination was: _____**

_____

_____.

☐ **Does comply with the requirements of the Policy and is otherwise complete, however:**

☐ **the Elder is not eligible for Medical Reimbursement Assistance under this Policy; or**

☐ **Medical Reimbursement Funding is no longer available.**

The Elders Specialist informed the Applicant of this determination, any right to an appeal the determination, including a description of the appeal procedure and a statement informing the Elder of their ability to reapply for assistance if their circumstances change, by ☐ U.S. Mail, ☐ email, or ☐ fax on: _____.

The reason for determination was: _____

_____

_____.