



Confederated Tribes of the Chehalis Reservation



Social Services

Emergency Medical Travel Assistance Policy

Emergency Medical Travel Assistance Application

Program Purpose:

The Emergency Medical Travel Assistance Program provides limited financial assistance to eligible enrolled Tribal members who must travel more than **51 miles round trip** for medically necessary healthcare appointments. Assistance is subject to annual funding availability and is limited to **\$500 per enrolled Tribal member per calendar year**.

Please Note: Incomplete applications or applications missing required documentation will not be processed.

APPLICANT INFORMATION

Applicant Name: _____

Tribal Enrollment Number: _____

Date of Birth: _____

Physical Address: _____

Mailing Address (if different): _____ ☐ Same as above

Primary Phone Number: _____

Alternate Phone Number: _____

Email Address: _____

MEDICAL APPOINTMENT INFORMATION

Medical Provider/Clinic Name: _____

Provider Specialty: _____

Provider Address: _____

Appointment Date: _____

Appointment Time: _____

Reason for Appointment (general description):

☐ Primary Care

☐ Surgery

☐ Orthopedic

☐ Pre/Post Surgical Appointment

☐ Cancer Treatment

☐ Physical Therapy

☐ Cardiology

☐ Neurology

☐ Mental Health



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☐ Specialist: _____ ☐ Terminal Illness Treatment ☐ Dialysis

☐ Other: _____

TRAVEL INFORMATION

Departure Location: _____

Medical Appointment Location: _____

Total Round-Trip Mileage: _____

Type of Assistance Requested (check one):

☐ 51–100 Miles Round Trip – \$25 Gas Card

☐ 101–149 Miles Round Trip – \$50 Gas Card

☐ 150+ Miles Round Trip – \$125 Gas Card

☐ Overnight Stay – \$150 Cut Check

If requesting an overnight stay, explain why overnight travel is necessary:

"
"
"
"

REQUIRED DOCUMENTATION

Please check all documents attached to your application:

☐ Appointment Verification Letter

☐ Appointment Reminder or Confirmation

☐ Medical Referral (if applicable)

☐ Additional Supporting Documentation

☐ Documentation Supporting Overnight Stay (if applicable)

Applications submitted without required documentation may be denied or delayed.



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APPLICANT CERTIFICATION

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that:

- Assistance is available only for qualifying medical travel exceeding 51 miles round trip.
- Assistance is based on the mileage schedule established by the Social Services Department.
- Overnight assistance is limited to \$100 per qualifying trip.
- The total Emergency Medical Assistance benefit is limited to \$500 per enrolled Tribal member per calendar year.
- Funding is subject to annual budget availability and is not guaranteed.
- Submission of false or misleading information may result in denial of assistance and may affect eligibility for future Tribal assistance programs.

Applicant Signature: _____

Date: _____

SOCIAL SERVICES USE ONLY

Date Application Received: _____

Received By: _____

Enrollment Verified ☐ Yes ☐ No

Appointment Verified ☐ Yes ☐ No

Mileage Verified ☐ Yes ☐ No

Previous Assistance Received This Calendar Year

\$ _____

Amount Requested

\$ _____

Amount Approved

\$ _____

Type of Assistance Approved



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☐ \$25 Gas Card

☐ \$50 Gas Card

☐ \$125 Gas Card

☐ \$150 Overnight Cut Check

☐ \$250 multiple Overnight Cut Check

☐ Denied

Reason for Denial (if applicable):

Director Approval: _____

Date: _____

Gas Card Number / Check Number: _____

Date Issued: _____

Comments: