

Delaware Nation

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SPECIAL DIABETES PROGRAM FOR INDIANS FY 2009-2010 APPLICATION for ASSISTANCE

DIABETIC SUPPLIES

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ AGE _____ BIRTH DATE _____

TRIBE _____ ENROLLMENT # _____

SOCIAL SECURITY # _____ MALE _____ FEMALE _____

APPROVAL MUST BE OBTAINED BEFORE ANY PURCHASE IS MADE!

____ COMPLETED/SIGNED APPLICATION

____ COPY OF CDIB

____ PRESCRIPTION FROM DR.

____ ORIGINAL INVOICE FROM APPROVED VENDOR **WITHIN 10 DAYS OF APPLICATION**

THE ABOVE AND ENCLOSED INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

APPLICANT AND/OR GUARDIAN SIGNATURE

DATE

DIRECTOR SIGNATURE

DATE

FOR OFFICE USE ONLY: APPROVED _____

DENIED _____

AMOUNT _____

REASON _____

REFERRED TO _____