

Delaware Nation

P.O. Box 825
Anadarko, OK 73005
405 / 247-2448
Fax: 405 / 247-9393

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

EYEGASSES

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 _____
AMOUNT _____

DENIED _____
REASON _____
REFERRED TO _____