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

THERAPEUTIC SHOES

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____________________