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

DENTURES

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 ______________