Delaware Nation

P.O.Box 825

Anadarko, OK 73005

405/247-2448

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SPECIAL DIABETES PROGRAM FOR INDIANS

FY 2016

APPLICATION FOR ASSISTANCE

Eyeglasses

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ AGE _____ BIRTH DATE _____

TRIBE _____ ENROLLMENT # _____

MALE _____ FEMALE _____

APPROVAL MUST BE OBTAINED BEFORE ANY PURCHASE IS MADE!

____ COMPLETED/SIGNED APPLICATION

____ COPY OF CDIB

____ PRESCRIPTION FROM DOCTOR

____ 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 _____