

Delaware Nation

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SPECIAL DIABETES PROGRAM FOR INDIANS

FY 2016

APPLICATION FOR ASSISTANCE

SHOES

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 _____