

# Delaware Nation

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## SPECIAL DIABETES PROGRAM FOR INDIANS

### 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 \_\_\_\_\_