



# **THE DELAWARE NATION ELDER ASSISTANCE PROGRAM**

## **APPLICATION INFORMATION SHEET**

The Delaware Nation Tribal Assistance Program (Formerly 10% Program) will be assisting eligible Enrolled Delaware Nation Elders.

### **ELIGIBILITY REQUIREMENTS:**

- Enrolled Delaware Nation tribal citizen
- 60 years of age or older upon submission of application

### **ASSISTANCE AVAILABLE:**

- **Major Dental:**
  - Extractions; root canals; crowns; and denture repair up to \$500 **once a year**
- **Glasses**
  - Up to \$400 **every two (2) years**
- **Dentures; Bridges; and Partial**s
  - Up to \$3,000 **every five (5) years**
- **Hearing Aid**
  - Up to \$3,000 **every five (5) years**

### **REQUIRED DOCUMENTATION:**

- Invoice from doctor and/or clinic

**PLEASE KEEP THIS PAGE FOR YOUR INFORMATION  
SUBMIT THE APPLICATION (PG.2) WITH YOUR INVOICE**

# THE DELAWARE NATION ELDER ASSISTANCE PROGRAM

## APPLICATION

PLEASE PRINT

Name \_\_\_\_\_ Enrollment# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### CHOOSE ONLY ONE BELOW

**Major Dental Work** up to \$500 (once a year)

**Glasses** up to \$400 (every 2 years)

**Dentures** up to \$3,000 (every 5 years)

**Hearing Aids** up to \$3,000 (every 5 years)

**Please attach an invoice to this application**

My signature below will indicate that I have agreed to the conditions listed on page one of this application to receive funding from this program. Applications without an invoice will be pending until one is submitted to Social Services.

\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SOCIAL SERVICES

You can mail for fax to:

Delaware Nation  
Social Services Department  
PO Box 825  
Anadarko OK 73005