SOCIAL SERVICES DEPARTMENT

PO BOX 825~ANADARKO OK~73005~PHONE (405)247-2448~FAX(405)247-5942

Medical Assistance Program

This program is for Delaware enrolled citizens that need assistance with purchasing durable medical equipment and/or prescriptions that is not covered by Medicare, private insurance or Indian Health Services. This program will be available to tribal citizens once a year up to $1,000.

This program <u>WILL NOT</u> pay for medical bills

***Please check the box that applies to you.**

☐ **Tribal Elder 60 years and older**

- Applicant must be considered disabled, physically disabled or mentally disabled by a physician. Or have a life threatening illness.

☐ **Tribal Citizen under 60 with medical disability**

- Applicant must be considered disabled, physically disabled or mentally disabled by a physician. Or have a life threatening illness.

REQUIRED DOCUMENTS The following documents must be submitted with this application. If you fail to submit these documents, your application will be placed on pending status.

- ✓ Copy of CDIB card
- ✓ Copy of prescription from the physician.
- ✓ Statement from the physician, clinic or hospital explaining your injury and/or disability.
- ✓ Proof of income
- ✓ Proof of insurance or Medicare

ATTENTION: Applicants must have denial statements from insurance, Indian Health Services or other medical facility in order to receive services. Denial must state that prescribed medical equipment or prescriptions are not covered by insurance or Indian Health Services.

DEADLINE
No deadline.

SERVICE AREA
Nationwide

DELAWARE NATION
Medical Assistance Program
P.O. Box 825 – Anadarko, OK 73005
Phone (405) 247-2448 / Fax (405) 247-5942

NAME _____
FIRST LAST M. I.

ADDRESS _____
STREET OR ROUTE CITY STATE ZIP

PHONE _____ ROLL # _____

Brief description of the emergency medical circumstances: _____

_____

_____

_____

Are you currently employed?	YES ☐	NO ☐	Employer?
If not employed, what type of income do you receive?			
How often do you get paid?	wkly ☐	biwkly ☐	Gross monthly income _____
Have you applied through I.H.S.?	YES ☐	NO ☐	If no, you must contact I.H.S.
Do you have private insurance?	YES ☐	NO ☐	
Will your insurance cover your medical request?	YES ☐	NO ☐	If no, explain.

_____ _____
Applicant signature **Date**

OFFICE USE ONLY:

Type of request ◯ **Wheelchair** ◯ **Walker** ◯ **Prescription** ◯ **Other**

If other please specify _____

Approved ☐ **Denied** ☐ **Date:** _____

_____
Social Service Director

_____
Tribal Administrator