

SOCIAL SERVICES DEPARTMENT

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

Prescription Assistance Program

The Prescription Assistance Program is a General Welfare Assistance program for Delaware Nation enrolled citizens (age 0-59) who need assistance with purchasing prescriptions and durable medical equipment (including copays) that are not covered by Medicare, Medicaid, private insurance or Indian Health Services. This program will be available to tribal citizens one-time per fiscal year up to \$500.

This program WILL NOT pay for medical bills or cover cost associated with medicinal/recreational marijuana.

All prescription medications or durable medical equipment must be prescribed by a licensed physician.

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 Delaware Nation enrollment card
- ✓ Invoice or paid statement/receipt (for reimbursement) from pharmacy or medical supply store indicating out-of-pocket costs for prescriptions or prescribed durable medical equipment only

ATTENTION: Delaware Nation will only reimburse or make payment for out-of-pocket costs. Reimbursements cannot be made for any portion paid by Medicaid/Medicare, private insurance, state health plans or Indian Health Services. If applying for multiple prescription reimbursements, please submit all paid invoices/receipts at one-time. Each citizen will be reimbursed one-time up to \$500 each fiscal year. You will not be eligible in the same fiscal year (October 1st-September 30th).

SERVICE AREA

Nationwide

Please submit application and all supportive documents to the Social Services department via email ssapplications@delawarenation-nsn.gov, fax (405) 247-5942 or mail.



DELAWARE NATION

Prescription 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 CITY STATE ZIP
ROUTE

PHONE _____ ROLL # _____

If available, have you applied through I.H.S.?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have private insurance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Will your insurance cover your prescription request?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Applicant Signature Date

OFFICE USE ONLY:

Approved Denied Date: _____

Social Service Director
