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 prescribed medications 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 prescription medications 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 ROUTE CITY STATE ZIP

PHONE _____ ROLL # _____

AGE _____

If available, have you applied through I.H.S.?	YES ☐	NO ☐
Do you have private insurance?	YES ☐	NO ☐
Will your insurance cover your prescription request?	YES ☐	NO ☐

_____ _____
Applicant Signature **Date**

OFFICE USE ONLY:

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

_____
Social Service Director

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