SOCIAL SERVICES DEPARTMENT

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

Dental Assistance Program

The Dental Assistance Program is a General Welfare Assistance program for Delaware Nation enrolled citizens (age 0-59) who need assistance with any dental services 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 $1,000.

This program WILL NOT pay for medical bills or past due balances.

All dental procedures must be performed by a licensed dental practice and within the fiscal year you are applying for.

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 dental office indicating procedure(s) performed and pricing to include any insurance payments and adjustments

PAYMENT PROCESS

For invoices submitted but have not yet been paid for or services not yet completed, payment will be made directly to the dental practice. If seeking reimbursement, invoices show the out of pocket payment made.

ATTENTION Delaware Nation will only pay/reimburse for out-of-pocket costs. Reimbursements can not be made for any procedures covered by private insurance, Medicare/Medicaid, state health programs or Indian Health Services. Once you have utilized this program, 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) 247-5948 or mail.

DELAWARE NATION
Dental 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 all or a portion of the assistance request?	YES ☐	NO ☐

☐ Please check here if 18 or older and have submitted a request for direct deposit and payment is not being made directly to vendor.

By signing this application, I certify under penalty of law that all information submitted in and with this form is true and accurate. I further certify that any misuse of funds will result in ineligibility of future participation in any Delaware Nation Assistance Program until funds are reimbursed. I accept the Terms and Conditions and agree to use these funds for the intended purpose stated within this application.

_____ _____
Applicant signature **Date**

OFFICE USE ONLY:

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

_____
Social Service Director

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