

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 (October 1st- September 30th) 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 again 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 socialservices@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 CITY STATE ZIP
ROUTE

PHONE _____ ROLL # _____

AGE _____

| | | |
|---|------------------------------|-----------------------------|
| 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 all or a portion of the assistance request? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

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

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 or fraudulently obtaining funds will result in a reimbursement of fraudulent funds obtained and ineligibility of future assistance for any Delaware Nation program for a period of time as determined by the Delaware Nation Fraud Policy and/or the court. 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 Services