ELDER OPTICAL ASSISTANCE APPLICATION FORM

Name: _____

      First   Middle   Last   (Maiden)

Address: _____

City: _____   State: _____   Zip Code: _____

Delaware Tribal Registration Number: _____

Date of Birth: _____   Age: _____   Applicant Phone: _____

Elder Optical Program:

- Provides assistance for optical services to Delaware Elders age 60 and over. Funds may be used for services, including glasses, physician's visits or related costs up to $200 annually. Payment for services will be made to the vendor.

Required Documentation:

- ✓ Copy of service provided billing/estimate or receipt. Provider name, address, phone, contact person and date of service **MUST** accompany the application.
- ✓ Copy of a photo ID (Driver's license, tribal photo ID) and Tribal enrollment card **MUST** accompany the application. Contact Enrollment Office for Cards.
- ✓ A short statement about situation for which assistance is requested.

Incomplete applications are not considered

- ➢ Approval of application must be obtained prior to the service payment.
- ➢ Non-Tribal members are not eligible for services.

Vendor/Provider Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Applications are approved on a case by case basis. Emergency applications are considered as received. Any tribal member purposely attempting to defraud the committee will be ineligible for any community service program for a period of one (1) year. (Applications are subject to change) **Also, Verification of Income shall be required**

Community Service Committee Use Only:

Approved By: _____ Date: _____

Total Amount: $ _____

Denied by: _____ Date: _____

Reason for Denial: _____
Revised: August 2015

Community Service Committee
Program Income Limits

*Applicants for all Community Service Programs must complete this form regarding income verification with the exception of Burial Assistance. Income verifications are required and **MUST** accompany the application in order for application to be considered. Include this form with completed program application. Please list all income in the household (1099, W-2, interest income, disability, social security, child support, unemployment, etc.)

Income limits for Community Services

1	2	3	4	5	6	7	8
$36,848	$42,112	$47,376	$52,640	$56,851	$61,062	$65,274	$69,485

1. How many members are in the household _____
2. Total gross household income_____
3. List all sources of income _____

By signing this form, I acknowledge that the information I have provided is true and/or correct to the best of know knowledge.

_____

Signature of Applicant

_____

Date