DELAWARE TRIBE OF INDIANS
Community Service Committee
5100 Tuxedo Blvd
Bartlesville, OK 74006
918-337-6590

ELDER PRESCRIPTION MED ASSISTANCE APPLICATION FORM

Name: _____
First Middle Last (Maiden)

Address: _____

City: _____ State: _____ Zip Code: _____

Delaware Tribal Registration Number: _____ E-Mail: _____

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

Elder Prescription Med Program:

- Provides prescription medication assistance to Delaware Elders age 60 and over for pharmacy and related cost. Funds may be disbursed to vendors or to Elders who provide proper documentation which must include an invoice or a receipt displaying vendor's name and method of payment. (credit card receipt, debit receipt or cancelled check)
- Funds may be disbursed to vendors or pharmacy on a monthly basis not to exceed $75 per month. Bills, statements, receipts or other proof of expenditure must be included with application.

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 needed.

Incomplete applications are not considered.

- ➢ Approval of application must be obtained prior to the service payment.
- ➢ Applications must be filled out and signed by an adult (18 years and over or Parent/Legal Guardian).
- ➢ Non-Tribal members are not eligible for services.

Vendor/Tribal member Name *(To whom check should be issued)*:_____

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)*

Community Service Committee Use Only:

Approved By: _____ Date: _____

Total Amount: $ _____

Denied By: _____ Date: _____

Reason for Denial: _____

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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 my knowledge.

_____
Signature (Must be 18 and over or Parent/Legal Guardian)

_____
Date

Personal Statement: