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: _____

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 Pharmacy 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 Applicant or pharmacy not to exceed $75.00 Elders must renew application annually. Elders may receive assistance not to exceed $ 75.00 per calendar year. 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 requested.
- ✓ **Income Verification Form** listing all sources of monthly income and documented proof of income.

Incomplete applications are not considered.

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

Applicant/Provider Name: _____Email address:_____

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)* ***Verification of Income shall be required.*

Community Service Committee Use Only:

Approved By: _____ Date: _____
Total Amount: $ _____
Denied By: _____ Date: _____
Reason for Denial: _____ Revised: April 2019 -AB

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 (salaries, interest income, disability, social security, child support, unemployment, etc.) and provide the most current documentation of listed income such as pay-stubs, statements, etc.**

Income limits for Community Services

Number of people in household:

1	2	3	4	5	6	7	8
$38,080	$43,520	$48,960	$54,400	$58,752	$63,104	$67,456	$71,808

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

Personal Statement: