



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 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. Elders must include a statement from the pharmacy showing the continuing service. This addresses Elders who have a long term monthly pharmacy bill. The Community Service Committee must approve arrangements for this type of payment. Elders must renew application annually. Elders may receive assistance not to exceed \$900 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.
- 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/Denied By: _____ Date: _____

Total Amount: \$ _____

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