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

MEDICAL 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: _____

Medical & Hospital Equipment Programs:

- Provides assistance for Delaware Tribal members for medical bills, including but not limited to, medical equipment (purchase or rental), home health care, pharmacy etc. Not to exceed $300. Payment for services will be made to the vendor. The Community Service Committee considers applications on a case-by-case basis.

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 required.

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).
- ➢ Must be a registered tribal member of the Delaware Tribe of Indians to apply.

Vendor/Provider 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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Notice to Applicants

As of July 14, 2022: Applications turned in 48 hours prior to scheduled Community Service meetings will not be considered until the following months meeting.

1. How many members are in the household? _____
2. Total gross household income? _____
3. List all sources of income: _____
4. *Do not forget to write a personal statement below on why these funds are being requested*.

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 (Required):