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

MEDICAL & HOSPITAL EQUIPMENT ASSISTANCE APPLICATION FORM

Name: _____
First Middle Last (Maiden)

Address: _____

City: _____ State: _____ Zip Code: _____

Delaware Tribal Registration Number: _____

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

Medical & Hospital Equipment Programs:

- (**MEDICAL**): Provides assistance for medical bills, including but not limited to, medical equipment (purchase or rental), home health care, pharmacy etc. Not to exceed $120.00 Payment for services will be made to vendor or applicant with receipt of purchase/payment..
- (**HOSPITAL EQUIPMENT**): Provides assistance for Delaware Tribal members partial cost of hospital equipment that is not paid for by the third parties. Funds may be used to pay for hospital equipment, which may include rentals, small equipment purchases or related costs up to $120.00 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 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: _____

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: