



**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 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.

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

**Committee Use Only:**

Approved By: \_\_\_\_\_ Date: \_\_\_\_\_

Total Amount: \$ \_\_\_\_\_

Denied by: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Denial: \_\_\_\_\_

# 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
\$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

***Personal Statement:***