



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

**OPTICAL 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: \_\_\_\_\_

**Delaware Tribe Optical Program:**

- ☐ Provides assistance for optical services to Delaware Tribal Members. Funds may be used for services, including glasses, physician's visits or related costs up to \$200 annually. Payment for services will be made to the vendor.

**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 needed.
- 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).
  - Non-Tribal members are not eligible for services.

Vendor/Tribal Member 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: \_\_\_\_\_

## OPTICAL ASSISTANCE APPLICATION FORM

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 my knowledge.

\_\_\_\_\_  
Signature (Must be 18 and over or Parent/Legal Guardian)

\_\_\_\_\_  
Date

***Personal statement:***