
# *MEDICAL ASSISTANCE APPLICATION*

***NAME:_____ENROLLMENT#_____MALE____FEMALE_____D.O.B._____***

***SOCIAL SECURITY#_____TELEPHONE:_____***

***MAILING ADDRESS:_____CITY:_____STATE:_____ZIP:_____***

***Attach copy of CDIB or enrollment card with this application.***

***FINANCIAL ASSISTANCE REQUESTED $100.00-ONLY ONE TIME PER TRIBAL MEMBER!!!!!***

***CHOOSE ONE CATEGORY: (ORIGINAL BILL OR RECEIPT MUST BE ATTACHED)***

1. ***_____EYEGLASSES OR CONTACTS***
2. ***_____HEARING AID***
3. ***_____DENTURES OR DENTAL PROCEDURE***
4. ***_____PRESCRIPTIONS (NOT AVAILABLE THROUGH IHS)***
5. ***_____MEDICAL BILLS***
6. ***_____HEALTH SUPPLIES (WALKER, CANES, WHEELCHAIRS, ETC.)***

***NAME AND ADDRESS OF VENDOR:_____***

***CITY:_____STATE:____ZIP:_____TELEPHONE:_____***

***SIGNATURE:_____DATE:_____***

***APPROVED_____DISAPPROVED_____DATE APPROVED_____***

***AMOUNT APPROVED_____SIGNATURE OF DIRECTOR_____***