ARPA 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 $200.00-ONLY ONE TIME PER TRIBAL MEMBER!!!!!

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

☐EYEGLASSES OR CONTACTS

☐HEARING AID

☐DENTURES OR DENTAL PROCEDURE

☐PRESCRIPTIONS (NOT AVAILABLE THROUGH IHS)

☐MEDICAL BILLS

☐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_____