Community Health Representative CHR Fax: 580/654-2971

Special Diabetes Fund

KIOWA DIABETICS ONLY DATE______________

SPECIAL DIABETES PROGRAM - *DENTURE* APPLICATION

NAME:____
First Middle Last

ADDRESS:____
Box/Street City Zip Code

TELEPHONE:_________________________ Date of Birth: _________________________

KIOWA CDIB #:_______________________

Any Diabetes information received might be verified by CHRs

Are you a Diabetic? ☐ Yes ☐ No

What medications are you taking for your diabetes?

____
____
____

Which Indian Health Service Facility do you receive your Diabetes Care? Check One

Lawton PHS☐ Anadarko Indian Clinic ☐ Carnegie Indian Clinic ☐ _____________ ☐

Date of last Diabetic Appointment:_______________________________________

Date of Diabetic Dental Exam:____

Which type of Dental Service do you need? Upper/Lower/Partial or Full Set (explain):

____

____

Applicant Signature:____

CHR Signature:____

(revised 2017)