**Community Health Representative** CHR Fax: 580/654-2971

## Special Diabetes Fund

KIOWA DIABETICS ONLY

## SPECIAL DIABETES PROGRAM – *EYE GLASS* APPLICATION

(Please Print) DATE:_____

NAME:_____
First Middle Last

ADDRESS:_____
Box/Street City Zip Code

TELEPHONE:_____

KIOWA CDIB #:_____

Any Diabetes information received might be verified by the CHR Program

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☐ OTHER ☐

Date of last Diabetic Appointment:_____

Date and Facility of Diabetic Eye Exam:_____

Which type of Eyeglass lens do you need? (check one): Single ☐ Bifocal ☐

***Kiowa Diabetes Program provides $200.00 for eyeglasses, any thing over will be the client's responsibility***

**Kiowa Diabetes Program is <u>not</u> responsible for lost, stolen or broken glasses.**

Applicant Signature:_____

CHR Signature:_____

Revised (2017)