KAW NATION
TRIBAL SOCIAL SERVICES
P.O. BOX 50, KAW CITY, OK 74641 TEL. # 580/269-1186 FAX # 580/269-2116 FLONG@KAWNATION.COM
WWW.KAWNATION.COM

APPLICATION FOR EYEGLASS, DENTURE, & HEARING AID ASSISTANCE

DATE: _____

Name: _____
(First) (Last) (Maiden)

Address: _____
(City) (State) (Zip Code)

Telephone #: _____ D.O.B.:_____ Kaw Roll #: _____

Currently employed: Yes _____No _____ Last date of employment:_____

LAST (4) DIGITS OF S.S. #: _____ Number in family:_____

Student: Yes ___ No___ Elder: Yes ___ No___ Diabetic: Yes ___ No___ Do you have a chart @ Kaw Clinic? _____

List Medicare, vision/dental insurance, state assistance, etc. :_____

Type of assistance requested: Please check all that apply on the left column.

____ Eyeglass Wear - $400.00 (approved amount every two years) TRB SS #6620 _____

____ Denture Work - $500.00 (approved amount every three years) TRB SS #6610 _____

____ Hearing Aid - $1000.00 (approved amount every five years) TRB SS #6635 _____

Please list your Patient ID # for the corresponding assistance requested:_____

Amounts exceeding the approved amount will be the responsibility of the applicant. All applications must be approved **BEFORE MAKING YOUR APPOINTMENT.** The Kaw Nation cannot make payments on previous balances prior to the application date.

_____
Signature of applicant – Parent/Guardian must sign application for minors

FOR OFFICE USE ONLY

Eligible: Yes _____ No_____ Application approved: _____ Denied _____

Reason for denial: _____

Eligible amount for: Eyeglasses $ _____ Dentures $ _____ Hearing Aid $ _____

_____ _____
Tribal Official/Representative Authorization Date

Approval letter mailed: _____ Submitted invoice to accounting: _____