KAW NATION TRIBAL SOCIAL SERVICES

P.O. BOX 50, KAW CITY, OK 74641 TEL. # 580/269-1186 FAX # 580/269-2116 WWW.KAWNATION.COM

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APPLICATION FOR EYEGLASS, DENTURE, & HEARING AID ASSISTANCE

DATE:				
Name:(First)		(Last)		(Maiden)
Address:		(City)	(State)	(Zip Code)
Telephone #:		•		Kaw Roll #:
Currently employed:	YesNo	Last da	te of employm	ent:
AST (4) DIGITS OF S.S. #: Number in family:				
Student: Yes No E	Elder: Yes No	Diabetic: Yes	_ No Do you h	nave a chart @ Kaw Clinic?
List Medicare, vision	n/dental insuran	ce, state assist	ance, etc. :	
Type of assistance re	equested: Please	e check all that	apply on the l	eft column.
Eyeglass Wear	- \$400.00 (appro	oved amount ev	ery two years)	TRB SS #6620
Denture Work -	\$500.00 (appro	ved amount eve	ery three years	s) TRB SS #6610
Hearing Aid - \$	1000.00 (approv	red amount ever	ry five years)	TRB SS #6635
	approved BEF (ORE MAKING	YOUR APPOI	y of the applicant. All <u>NTMENT.</u> The Kaw Nation ion date.
Signature of applicar	nt – Parent/Gua	rdian must sign	n application f	or minors
	<u>F(</u>	OR OFFICE US	E ONLY	
Eligible: Yes				
Reason for denial: _				
Eligible amount for:	Eyeglasses \$	Dentur	res \$	Hearing Aid \$
Tribal Official/Representative Authorization				Date
Approval letter mail	ed:	Submitt	ed invoice to a	accounting: