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

APPLICATION FOR DIABETIC EYEWEAR 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:_____

Diabetic: Yes ___ No___ Are you a patient at the Kanza Clinic? _____ If so, do you attend the Diabetic Program? _____

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

Please attach documentation showing that you are a diabetic patient from your doctor/service provider.

____ Eyeglass Wear - Up to $400.00 (approved amount every year) TRB SS #6620 _____

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. By signing, you certify that you are an enrolled citizen of the Kaw Nation. Dual enrollment with another tribe is not allowed. If evidence of dual enrollment is found, this application will be void and services will be denied. If evidence of dual enrollment is found after services are received, legal action may be taken to recover any benefits awarded.

FOR OFFICE USE ONLY

Eligible: Yes _____ No_____ Application approved: _____ Denied _____

Reason for denial: _____

Eligible amount for: Eyeglasses $ _____ Diabetic Program verified on: _____

Tribal Official/Representative Authorization: _____ _____
Date

Approval letter mailed: _____ Submitted invoice to accounting: _____