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

APPLICATION FOR EYEGLASS, DENTURE, & HEARING AID ASSISTANCE

DATE: _____ PLEASE ATTACH HOUSEHOLD INCOME VERIFICATION, SNAP, ETC.

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 _____

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: _____