Wichita & Affiliated Tribes
SPECIAL DIABETES PROGRAM FOR INDIANS
APPLICATION FOR ASSISTANCE

Name: _____ Date: _____

Address: _____
P.O. Box Number/Street Address City State Zip Code

D.O.B. _____ Phone# _____ WK# _____

Tribal Affiliation: _____ CDIB# _____

Type of assistance requested: (Please check type of assistance)

Walking Shoe [ ] Therapeutic Shoe [ ] Dentures [ ]

Referral made to:
Physician [ ] Podiatrist [ ] Dentist [ ]

Referral by: _____ Date: _____

Statement of Diagnosis: I have a diagnosis of diabetes and have had my annual examination for:
(Please check type of annual examination completed)
Feet [ ] Teeth [ ]

I understand that all payments will be made in the name of the Vendor and I will supply any supporting documentation required to process payment.

Vendor Information:
Request Payments Be Made To: _____

Address: _____ City: _____ Zip: _____

_____ _____
Signature of Client Date

(FOR OFFICE USE ONLY)

Application Receive On: _____ Application Complete On: _____

Enrollment Verified: _____ Proof of Residency: _____ Verifying Official: _____

Verifying Official: _____ Approved By: _____ Disapproved By: _____

STATEMENT OF CERTIFYING HEALTH PROVIDER

Patient Name: _____ AIHC# _____ LIH# _____

THERAPEUTIC SHOES

I certify that all of the following statements are true:

1. This patient has Diabetes Mellitus _____.
2. The date a comprehensive foot exam was completed. _____
3. This patient has one or more of the following conditions. (Circle all that apply)
    a. History of partial or complete amputation of the foot.
    b. History of previous foot ulceration.
    c. History of pre-ulcerative callus.
    d. Peripheral neuropathy with evidence of callus formation.
    e. Foot deformity.
    f. Poor circulation.
    g. Preventive Measures.
4. This patient requires special shoes (depth or custom molded shoes because:
   Description of type of shoe necessary for patient: _____
5. This patient does not require a therapeutic shoe, but requires a good walking shoe: _____

_____ _____

Name of Podiatrist Date

DENTURES

I certify that all of the following statements are true:

1. This patient has Diabetes Mellitus _____.
2. This patient needs dentures to help maintain a proper diet to keep his/her diabetes in control. _____
3. This patient is under a dental plan of care for his/her diabetes. _____

_____ _____

Name of Dentist Date