Wichita and Affiliated Tribes
Tribal Funded Program for Diabetics & Elders
APPLICATION FOR ASSISTANCE

Today's Date: _____

Name: _____ (Maiden)_____ CDIB#_____

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

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

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

Hearing Aid	[ ]	Nutritional Supplement	[ ]	Dentures	[ ]
Walking Shoes	[ ]	Therapeutic Shoes	[ ]	Partials	[ ]

Statement of Diagnosis: I have a diagnosis of diabetes and have had my annual examination for:
(Please check type of annual examination completed, Make sure the Provider has signed the statement on back)
Hearing [ ] Feet [ ] Teeth [ ]

Reimbursement: Original Receipt must be turned in at time of application submission along with any supporting documentation.
Request Payments Be Made To: _____

Address: _____ City: _____ Zip: _____

_____ _____
Signature of Client Date

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) **modified 8/1/2013**

Application Receive On: _____ Application Complete On: _____

Enrollment Verified: _____ Date Paid: _____ Check #: _____

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

P.O. Box 729
Anadarko, Ok 73005
405-247-2425 Ext. 158

STATEMENT OF CERTIFYING HEALTH PROVIDER

Patient Name: _____ AIHC# _____ LIH# _____

THERAPEUTIC/WALKING 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

Hearing Aids

I certify that all of the following statements are true:

1. This patient has Diabetes Mellitus _____.
2. This patient needs the aid of a Hearing device. _____.
3. Date of last Audiology exam. _____(Must be current to be eligible for service)

_____ _____
Name of Audiologist Date

DENTURES/PARTIALS

I certify that all of the following statements are true:

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

_____ _____
Name of Dentist Date

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