Wichita and Affiliated Tribes
Health Programs
Eyeglass and Medication
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)

Eyeglasses [ ] Single Vision (Max $100.00) ___ Bifocals (Max $125.00) ___ Trifocals (Max $150.00) ____Diabetics (Max $200.00) ____
Prescription Drugs/ Medical Equipment [ ] (Max of $100.00)
Type of Equipment or Prescription: _____
Nutritional Supplements [ ]: _____
(Must have RX)

Dependent's Information: (Applies ONLY assistance is requested for a minor child (ren)

Name of Child (ren)	Age	D.O.B.	CDIB#	Relationship
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

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 or Guardian 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 or Guardian Date

(FOR OFFICE USE ONLY) **modified 7/08/14**

Application Receive On: _____ Application Complete On: _____
Enrollment Verified: _____ Verifying Official: _____
Eligibility Verified: _____ Verifying Official: _____
Approved By: _____ Disapproved By: _____
Date Paid: _____ Check #: _____

P.O. Box 729
Anadarko, Ok 73005
405-247-2425 ext.158, Fax 405-247-7511