

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