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