WICHITA AND AFFILIATED TRIBES
SPECIAL DIABETES PROGRAM FOR INDIANS
APPLICATION FOR ASSISTANCE
P.O. BOX 729 · ANADARKO, OK 73005 · 405.247.8660

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)

Medical ID ☐ Wellness Shoes ☐ Sharps Container ☐

Other: _____

Referral made to:

Physician ☐ Podiatrist ☐ AIHC for Nail Care ☐

Referral by: _____ Date: _____

Statement of Diagnosis: I have a diagnosis of diabetes and have had my annual examination for:

Feet ☐

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: _____

Approved By: _____ Disapproved By: _____