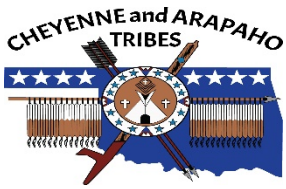
Concho Office
Mon-Fri 8 a.m.-5 p.m.
P.O. Box 133
Concho, OK 73022
405-422-7411, Office
405-422-8230, Fax
1-800-247-4612 ext. 27411



Clinton Office
Mon-Fri 8 a.m.-5 p.m.
P.O. Box 714
Clinton, OK 73601
580-331-2317, Office
405-422-8229, Fax

Elder Care Program

Application for 90 Day, Medical/Dental

(Must be 55 or older and an active client)

eldercare@cheyenneandarapaho-nsn.gov

Applicant Information

Print Enrolled Name _____ CDIB# 2801A: _____
First M.I. Last

Address: _____
Mailing Address City State Zip Code

_____
Physical Address Must be provided *City State ZIP Code*

Phone: _____ Date of Birth _____

90 Day Rental/Mortgage/Utility Assistance

One (1) request for assistance per household every 90 days from date of last assistance. Maximum allowable amount for 90 Day Assistance is up to $200 on the current amount.

_____ Rental/Mortgage Assistance –Submit a copy of **current** lease or **mortgage statement** with application **each time you apply. We do not accept eviction notices, notice to quit or deposit paperwork.**

_____ Utility Assistance- Submit all **pages of current utility bill and we pay current amount only. We do not pay on street lights.** No past due bills, final bills or disconnect notices accepted. *** **Last day to submit a bill is the day bill is due*****

Medical Assistance

One (1) request per assistance, up to $200 on current amount. Must provide current RX & invoice for all medical assistance. ***No cosmetic procedure paid for on Medical/Dental***

_____ Eyeglasses-Every two (2) yrs. Must provide valid RX & Invoice. Assist with only one (1) pair of glasses **(no eye exams paid for)**

_____ Prescriptions-Quarterly assistance on one (1) prescription with valid RX & Invoice. **(no narcotics)**

_____ Medical Supplies/Equipment-Quarterly Assistance**. Diabetic shoes once yearly, valid RX & invoice**

_____ Medical/Hospital Visits-Twice yearly on one (1) service, (Jan-June) (July-Dec) payment after insurance

____ Dental-Twice yearly on one (1) service, (Jan-June) (July-Dec) payment after insurance

_____ _____
Tribal Member Signature MM/DD/YY

REV. July 2019 *****Elder Care Program does not reimburse on any services provided*****