

**KAW NATION
TRIBAL SOCIAL SERVICES PROGRAM**

P.O. Box 50, Kaw City, OK 74641 Tel.# 580/269-1186 Fax # 580/269-2116
WWW.KAWNATION.COM

APPLICATION FOR EYEGLASS, DENTURE, & HEARING AID ASSISTANCE

Date: _____ **PLEASE LIST YOUR KAW ENROLLMENT NUMBER BELOW**

Name: _____
(First) (M.I.) (Last)

Address: _____
(Street or Box #) (City) (St.) (Zip Code)

Telephone: _____ D.O.B.: _____ Roll #: _____

Currently Employed: Yes _____ No _____ Last Date of Employment _____

Social Security #: _____ Number in family: _____

Student: Yes _____ No _____ Elder: Yes _____ No _____ Diabetic: Yes _____ No _____

Type of Assistance Requested Amounts exceeding approved amount will be the responsibility of the applicant (Please Check All That Apply)

_____ Eyeglass Wear - \$350.00 (approved amount every two years) #10.6620 - _____

_____ Denture Work - \$300.00 (approved amount every two years) #10.6610 - _____

_____ Hearing Aid - \$1,000.00 (approved amount every five years) #10.6635 - _____

Amounts exceeding the approved amount will be the responsibility of the applicant.
All Applications must be approved **BEFORE** making your appointment. The Kaw Nation cannot make payments on previous balances prior to the application date.

Signature of applicant - Parent/Guardian must sign applications for minors

FOR OFFICE USE ONLY

Eligible: Yes _____ No _____ Application Approved: _____ Denied: _____ Date: _____
Reason for denial: _____

Eligible Amount for: Eyeglasses \$ _____ Dentures \$ _____ Hearing Aid \$ _____

Tribal Official or Representative Authorization Date

Mailed approval letter: _____ Submitted invoice to accounting: _____