KAW NATION
TRIBAL SOCIAL SERVICES
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) (Last) (Maiden)

Address: _____
(City) (State) (Zip Code)

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

Currently employed: Yes _____ No _____ Last date of employment _____

Social Security #: _____ Number in family: _____

Student: Yes _____ No_____ Elder: Yes _____ No_____ Diabetic: Yes _____ No_____

Please list other resources such as Medicare, insurance, etc.: _____

Type of assistance requested: Please check all that apply on the left column.

_____ Eyeglass Wear - $350.00 (approved amount every two years) TRB SS #6620 _____

_____ Denture Work - $500.00 (approved amount every three years) TRB SS #6610 _____

_____ Hearing Aid - $1000.00 (approved amount every five years) TRB SS #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 application for minors

## FOR OFFICE USE ONLY

Eligible: Yes _____ No_____ Application approved: _____ Denied _____

Reason for denial: _____

Eligible amount for: Eyeglasses $ _____ Dentures $ _____ Hearing Aid $ _____

_____ _____
Tribal Official/Representative Authorization Date

Approval letter mailed: _____ Submitted invoice to accounting: _____