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) #6620 - _____

_____Denture Work - $500.00 (approved amount every three years) #6610 - _____

_____Hearing Aid - $1,000.00 (approved amount every five years) #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 :_____***

Reason for denial: _____

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

_____ _____
Tribal Official or Representative Authorization ***Date***

Mailed approval letter: _____ ***Submitted invoice to accounting:_____***