Caddo Nation of Oklahoma
Community Health Services
405/656-2882 - FAX 405/656-2468
Post Office Box 487
Binger, Oklahoma 73009

HEALTH SERVICES PROGRAM
APPLICATION FOR ASSISTANCE

NAME:______________________________Enrollment#______ Male_____Female_____D.O.B._______

Social security#_____________________ Telephone:______________________

Mailing Address:_____________________City:_______________________State______ Zip_________

Diabetic: Yes or No **Attach copy of CDIB or enrollment card with this application.**

FINANCIAL ASSISTANCE REQUESTED
CHOOSE ONE CATEGORY ONLY – ONE TIME PER TRIBAL MEMBER EACH YEAR
$200.00 MAXIMUM ASSISTANCE **(ORIGINAL BILL/RECEIPT MUST BE ATTACHED)**

_________EYEGLASSES AND/OR CONTACT LENSES

_________HEARING AIDS

_________DENTAL/PROTHESIS

_________RX/MEDICAL BILL

_________HEALTH EQUIPMENT

NAME &ADDRESS VENDOR:____

CITY________________________ STATE__________ ZIP_________

CERTIFICATION

I certify that the information submitted on this form is true to the best of my knowledge.

____ ________________________________
SIGNATURE DATE

APPROVED__________ DISAPPROVED_______ DATE APPROVED____________

AMOUNT APPROVED_______________

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APPROVING OFFICIAL

NOTICE