

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@cheyenneandrapaho-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