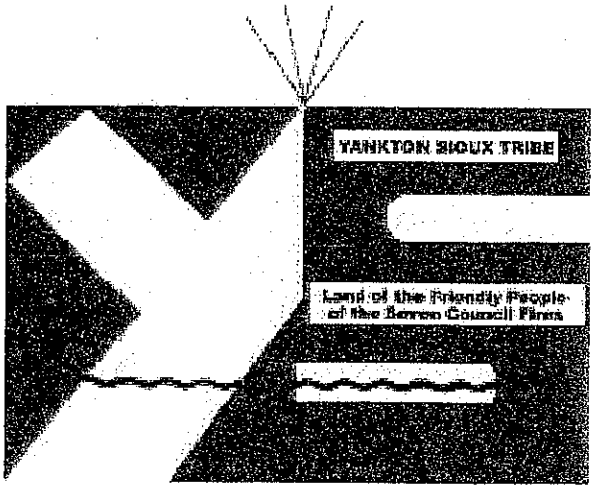

Tribal Health Administration

P.O. Box 1153

800 South Main

Wagner, SD 57380

Phone: 605-384-3641

Fax: 605-384-3968

OPTOMETRY APPLICATIONS

DATE: _____

NAME: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME NUMBER: _____ CELL NUMBER: _____

DIRECTIONS TO HOME: _____

TRIBE: _____ ENROLLMENT NUMBER: _____

****

ELIGIBILITY CRITERIA

ELDERLY: YES_____ NO_____ DIABETIC: YES _____NO_____

HANDICAPPED/DISABLED: YES _____NO_____

****

SUPPLEMENT RESOURCES

Medicare: _____Medicaid/Title 19: _____Private Insurance: _____

NAME OF PRIVATE INSURANCE PROVIDER: _____

**********APPLICATION CONTINUED ON NEXT PAGE**********

ASSISTANCE PROGRAM BENEFITS

BIA/GA: _____ SS: _____ SSI: _____ VA: _____ AFDC/TANF: _____

INCOME: MONTHLY: _____ BI-WEEKLY: _____ WEEKLY: _____

TOTAL AMOUNT OF ALL ASSISTANCE/BENEFITS FOR ONE MONTH: $ _____

****

EMPLOYMENT STATUS

EMPLOYED: YES _____ NO_____ EMPLOYER: _____

PHONE: _____ SUPERVISOR: _____

POSITION: _____ HOURLY WAGES/SALARY: $_____

****

SERVICE HISTORY

HAVE YOU RECEIVED SERVICES FROM THIS PROGRAM IN THE PAST YEAR? YES_____NO_____

DATE OF LAST EYE EXAM: _____

IF YOU RECENTLY HAD AN EYE APPOINTMENT AND ARE NOW REQUESTING ASSISTANCE WITH PURCHASING YOUR EYE WEAR PLEASE LIST THE TOTAL COST/OR ATTACH THE INVOICE. $_____

APPOINTMENT DATE: _____ TIME: _____

SERVICE REQUESTING: EXAM _____ FRAMES _____ LENS _____ BOTH_____

*THE YST OPTOMETRY PROGRAM WILL ONLY PAY FOR THE BASIC COST OF LENS/FRAMES

*UNLESS A SPECIAL NEEDS STATEMENT IS GIVEN BY THE OPTOMETRIST

*WE WILL NOT PAY FOR AN EXAM UNLESS A JUSTIFIABLE REASON IS GIVEN

*THE SET RATE IS $100.00

_____ _____

APPLICANTS SIGNATURE **DATE**