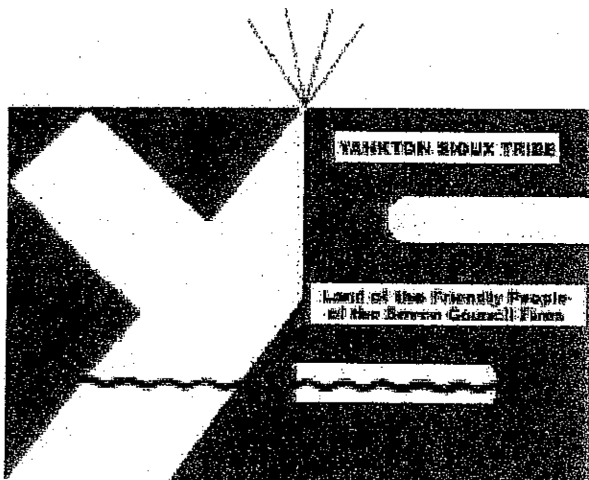

Tribal Health Administration

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