Application
Elder Care & Disability Reimbursement Program

PO Box 1527, Miami, OK 74355
918-540-2535

Tribal Member Name: ____

Address: ____
City/State/Zip Code

Phone Number: ____

(Only 3 applications will be accepted per tribal member per fiscal year)

Tribal Roll #:_________________Birth date: _________
(Attach copy of membership card)

Program Applying for: (check one)

Elder Care: ______ **Disability**: _____

Total of attached receipts: $_______________

MUST BE ATTACHED: (check list below)

☐ Copy of Tribal Membership Card

☐ Copy of Photo I.D.

☐ ***Original RECEIPTS*** of Purchases for items or services (stated in guidelines)

Disability applicants will also need:

☐ Award Letter, Benefit Statement or Determination of Disability documentation.

I hereby give permission to the Special Projects Manager to verify my Tribal enrollment with the Tribal Enrollment Office.

Date: _______________ Signature:_______________________________________

DO NOT WRITE BELOW THIS LINE/OFFICE USE ONLY

Date Received: _________ Membership confirmed: ______Reimbursement Requisition ____ Check mailed______