Apache Tribe of Oklahoma
Special Diabetes Program for Indians (SDPI)
Request for Diabetes Health Services

You must complete and submit all documentation listed below to determine if you are eligible for diabetic health services.

1.) _____ Application
2.) _____ Degree of Indian Blood Card (CDIB)
3.) _____ Statement of Certifying Health Provider
4.) _____ Copy of prescription
5.) _____ Invoice from vendor/supplier

Due to limited funding, the Diabetic Health Services are available to qualifying participants once a year.

- Complete application
- Attach a copy of your CDIB
- Need a doctor's signature on the Health Provider form. This can be the optometrist if applying for eyeglasses, the podiatrist if applying for diabetic shoes, or the dentist if applying for dentures.
- Copy of your eyeglass or shoe prescription.
- Once these are completed, please bring or fax this application with the required documentation.
- If you are eligible, THEN you will be referred to the appropriate vendor to place your order.

Copies can be made of your required documents at the CHR Office, if necessary.

Upon completion of application your application will be processed by ATO Finance Department. Please DO NOT contact the Finance Department to verify the status of your check. You will be notified when payment has been made to the vendor. For more information or need assistance with picking up your eyeglasses, shoes, dentures, or medications please contact the:

Apache CHR Office at (405)247-7000 Phone (405)247-2763 Fax Number

Apache Tribe of Oklahoma

SPECIAL DIABETES PREVENTION FOR INDIANS

APPLICATION FOR ASSISTANCE

***MUST BE ENROLLED APACHE TRIBAL MEMBER TO RECEIVE DIABETIC SERVICES**

Name: ______________________________ **Date:** ____________________

Address: ____

P.O Box, Street Address, or RR# **City** **State** **Zip Code**

D.O.B. __________ **Home Phone#** ____________________ **Work/cell#** ____________

Tribal Affiliation: **Apache Tribe of Oklahoma** **CDIB NO:** ____________________

Type of assistance requested: **(Please check type of assistance)** **Medications []**

Eyeglasses [] **Walking Shoes []** **Therapeutic Shoes []** **Dentures []**

REFERRAL MADE BY: **Physician []** **Podiatrist []** **Optometrists []** **Dentist []**

Referred by physician: ________________________ ____________________

Date

STATEMENT OF DIAGNOSIS:

I have a diagnosis of Diabetes and have had my annual examination. Please check type of annual examination completed: Eyes [] Feet [] Teeth []

I understand that all payments will be made to the name of the Vendor and I will supply all supporting documentation required to process payment.

Due to limited funding all Diabetic Health Services are available on a **one time** only basis during the current funding cycle.

______________________________ ____________________

Signature of Client **Date**

VENDOR INFORMATION:

Request Payments Be Made To : ______________________________

Address: ______________________________

City & Zip Code: ______________________________

Phone: ______________________________

(FOR OFFICE USE ONLY)

Application Received On ______________ Application Complete On: ______________

Enrollment Verified: ________ Date Paid: ____________ Check #: ______________

Approved by: ______________________ Disapproved by: ______________

APACHE TRIBE of OKLAHOMA

SPECIAL DIABETES PROGRAM for INDIANS (SDPI)

STATEMENT OF CERTIFYING HEALTH PROVIDER

Patient Name: ______________________ Date of Birth: ______________________

DIABETIC SHOES/THERAPEUTIC SHOES

I certify that all of the following statements are true: **YES** **NO**

1. This patient has Diabetes Mellitus. ______ ______
2. The date a comprehensive foot exam was completed. ______________________
3. This patient has one or more of the following conditions.
   (Circle all that apply)
   a. History of partial or complete amputation of the foot.
   b. History of previous foot ulceration.
   c. History of pre-ulcerative callus.
   d. Peripheral neuropathy with evidence of callus formation.
   e. Foot Deformity.
   f. Poor circulation.
   g. Preventive Measures.
4. This patient requires special shoes depth or custom molded shoes because:
   Description of type of shoe necessary for patient: ______________________
   ____
5. This patient does not require a therapeutic shoe, but requires a good walking shoe:
   ____

______________________ ______________________
Name of Podiatrist **Date**

EYEGLASSES

I certify that all of the following statements are true: **YES** **NO**

1. This patient has Diabetes Mellitus. ______ ______
2. This patient needs eyeglasses due to a change in his/her Prescription. ______ ______
3. Date of last dilated eye exam ______________________
   (Must be current to be eligible for services)

X______________________ ______________________
Name of Optometrist **Date**

DENTURES

I certify that all of the following statements are true: **YES** **NO**

1. This patient has Diabetes Mellitus. ______ ______
2. This patient needs dentures to help maintain a proper diet to keep his/her diabetes in control. ______ ______
3. This patient is under a dental plan of care for his/her diabetes. ______ ______

______________________ ______________________
Name of Dentist **Date**