COVID-19 RESPONSE PROGRAM

208 Hardee West Street ▪ Anadarko, Oklahoma ▪ 73005
(405) 648-0492 ▪ ss01@kiowatribe.org

MEDICAL ASSISTANCE PROGRAM

General Information

The Medical Assistance Program, under the Kiowa Tribe COVID-19 Response Program, is intended to alleviate the financial hardship associated with unmet medical services. This program provides financial assistance for medical and dental services when all other resources, such as insurance, have been exhausted. The eligible medical assistance is as detailed below:

- Dental Assistance – for the purpose of routine dental visits or minor procedures
- Glasses Assistance – for the purpose of acquiring one (1) complete pair of eyeglasses
- Office & Hospital Visits – for the purpose of traveling to receive specialized services from a medical provider outside of Indian Health Services
- Prescription Assistance – for the purpose of purchasing medical necessary medication or supplies and equipment required with a medical diagnosis

It is the responsibility of eligible Tribal members to initiate request. Information will only be taken and shared with the authorized individual who is completing the request.

Eligibility Requirements

- **Applicant must be able to verify that he/she was positive for COVID within the past six (6) months.**

The Medical Assistance Program is provided on a first-come, first-serve basis. Funding will **NOT** be provided unless the following criteria is met:

A completed request form with all required documents:

- ☐ Request Form – completed, signed, and dated
- ☐ Copy of Tribal I.D. Card – verifying Kiowa Enrollment
- ☐ Copy of Invoice from Medical Provider – demonstrating incurred expenses
- ☐ Copy of Medical Referral or treatment plan
- ☐ Copy of Current Valid Prescription
- ☐ Copy of a Positive Covid Test Result

Note: There will be a processing period after the request is completed, and documents required for the Medical Assistance Program must be submitted before the request can be processed

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MEDICAL ASSISTANCE PROGRAM

Date: _____

Patient Information:

Name:	
Birthdate:	Tribal I.D Number:
Address:	City/State/Zip:
Phone Number:	
Reason for requesting assistance:	

Please select one of the following that best fits your needs:

- ☐ Dental Assistance
- ☐ Glasses Assistance
- ☐ Office & Hospital Visits
- ☐ Prescription Assistance

Medical Provider/ Vendor Information: Must attach invoice and current prescription or referral

Name of Doctor/Vendor:	
Mailing Address:	City/State/Zip:

Acknowledgement and Signature:

The above information is correct to the best of my knowledge. I acknowledge that the Kiowa Tribe COVID-19 Response Program reserves the right to revise, modify, delete, or add to any of the Medical Assistance Program. I understand that all services received are the patient's responsibility as the agreement is between the patient and the provider. Further, I understand that any false statement or information provided in this form is in violation of federal law. Any misinformation or fraud will be investigated, and I will be responsible to refund the program.

_____ _____

SIGNATURE DATE