Community Health Representative CHR Fax: 580/654-2971

Special Diabetes Fund

KIOWA DIABETICS ONLY

SPECIAL DIABETES PROGRAM – *EYE GLASS* APPLICATION

(Please Print) DATE:________________

NAME:____
First Middle Last

ADDRESS:____
Box/Street City Zip Code

TELEPHONE:_____________________________________

KIOWA CDIB #:_____________________________

Any Diabetes information received might be verified by the CHR Program

Are you a Diabetic? ☐ Yes ☐ No

What medications are you taking for your diabetes?

____

____

____

Which Indian Health Service Facility do you receive your Diabetes Care? Check One
Lawton PHS☐ Anadarko Indian Clinic ☐ Carnegie Indian Clinic☐ OTHER ☐

Date of last Diabetic Appointment:____

Date and Facility of Diabetic Eye Exam:____

Which type of Eyeglass lens do you need? (check one): Single ☐ Bifocal ☐

Kiowa Diabetes Program provides $200.00 for eyeglasses, any thing over will be the client's responsibility

Kiowa Diabetes Program is <u>not</u> responsible for lost, stolen or broken glasses.

Applicant Signature:____

CHR Signature:____

Revised (2017)