

HEALTH AID FOUNDATION
GENERAL INFORMATION, GUIDELINES AND APPLICATION

The Citizen Potawatomi Nation Business Committee is continually striving to improve benefits to all of our Tribal Members regardless of where they live.

Applicant must be an enrolled Citizen Potawatomi Nation Tribal Member and born by December 31, 1971 or be at least 1/8 blood degree.

THE FOLLOWING MUST BE COMPLETED before the application will be submitted to the HAF Committee:

Application must be completed by Tribal Member.

Detailed Itemized Statement: (Must be from Doctor or Business)

Patient's Name, Date of Service, Description of Device, Cost of device, Address and phone number of Doctor or Vendor, and Doctor or Vendor's name, signature or signature stamp.

Program monies are to be used for the purchase of:

Eyeglasses	Partials	CPAP Machines
Contacts	Bridgework	Mobile Chair lifts and ramps for vehicles
Prescription Sunglasses	Crowns	Prosthetic Devices
Hearing Aids	Wheelchairs	
Dentures	Mobile Chairs	

Prescription Sunglasses must have a Doctor's statement stating that they are medically necessary. If a statement is not submitted with the application the HAF will not pay for the additional charge.

AUTHORIZED EXPENDITURE LIMITS:

The selection board may authorize expenditures, which shall not exceed 75% of the cost of the device(s). During the program year, no one individual may be authorized to collect more than \$750.00. If the Applicant has insurance available for the prosthetic device(s), HAF will pay 75% of the remaining balance, up to \$750.00 per year. The program year is January through December.

APPROVAL:

Completed applications will be individually and collectively reviewed on the 3rd Thursday of every month. Applications will not be considered if information is lacking.

The following criteria must be met to be eligible:

1. Tribal Membership Requirements- must be enrolled with the Citizen Potawatomi Nation and born by December 31, 1971 or be at least 1/8 blood degree.
2. Need for Device Must Exist- must be prescribed by a licensed health professional.
3. **Applications received after the Monday before the 3rd Thursday of December will be considered in January of the following year.**

DENIALS:

1. Any itemized statements with a date of service over a year old will not be considered.
2. Applicant does not meet membership requirements.
3. Applicant has reached maximum amount of \$750 for the year running January through December.
4. The Health Aid Foundation will not pay for examinations, procedures, x-rays, routine dental work, surgery, extractions, medication, orthodontics or taxes.

Health Aid Foundation Application

Citizen Potawatomi Nation
Health Aid Foundation
1601 S. Gordon Cooper Dr.
Shawnee, OK 74801
(405) 275-3121 or 1-800-880-9880
Fax (405) 395-0546

**** Please note: This process takes 4-6 weeks****
***** All checks that are issued will be void after 90 days and will not be reissued*****

Joyce Abel, RN
Director
JMAbel@potawatomi.org

Amber Brewer
Administrative Assistant
ARBrewer@potawatomi.org

Patient Information - This application is to be filled out by the Tribal Member only.

First: _____ Last: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security Number: _____ ID #: _____

Please check (X) one of the following prosthetic device(s) needed:

- Prosthetic Description _____
- Crown(s) Tooth/Teeth #(s) _____
- Bridgework Tooth/Teeth #(s) _____
- Hearing Aid(s) Right Left Both
- Partial(s) Upper Lower Both Denture(s) Upper Lower Both
- Eye glasses Contacts Prescription Sunglasses (Must have a Doctor's statement)
- CPAP Machine Wheelchair Mobile Chair Mobile Chair lift or ramp for vehicle

Do you have insurance that will assist with this device? Yes No

If so, you must send an Explanation of Benefits before the Health Aid Foundation will pay on the device.

Dr. or Vendor's Name: _____ Phone: _____

(Check will be made out to Tribal Member and Vendor unless the Itemized Statement shows a \$0 balance due.)

Would you like to be contacted about any health issues you may have? Yes No

I have received and read the Health Aid Foundation guidelines.

Tribal Member Signature: _____ Date: _____

I have attached the following with my completed application.

- Itemized Statement from Doctor/Vendor's office.
- EOB (Explanation of Benefits) if insurance is assisting with the cost of the above device.
- Doctor's statement or prescription if I am applying for Sunglasses.