



Peoria Tribe
Elder Care and Disability
Reimbursement Program

Policies and Procedures

Elder Care and Disability Reimbursement Program

Program Description

The Peoria Tribe of Indians of Oklahoma has established a program to aid the elderly population that could benefit from an additional funding source to supplement their households, and/or disability needs, without restricting or interfering with other government programs.

The Elder Care and Disability Reimbursement Program (ECDRP) will make available up to \$500 per fiscal year (April 1st- March 31st) for eligible tribal members. Each eligible tribal member may only choose from one program to receive reimbursement, being limited to 3 requests for services per fiscal year, not to exceed maximum total of \$500. All denied benefits will be reviewed by a 3 person Review Committee comprised of the Chief and 2 accounting staff members. Individuals will not be permitted to receive benefits as both “elderly” and “disabled.” **Applicants may only utilize one program.**

Qualifications Criteria:

- Individual must be an **enrolled member** of the Peoria Tribe of Indians of Oklahoma, evidenced by Tribal Enrollment Card to receive benefits.
- Eligible tribal member must be **65 years or older**, evidenced by a Photo I.D. to receive benefits.
- Eligible **adult** tribal member must provide an award letter or benefit statement from the Social Security Administration (dated within last 90 days), to receive disability benefits. **No other proof of disability will be accepted.**
- Minors or other disabled individuals already receiving Disability Social Security or SSI benefits payable to a representative payee, will be eligible for tribal reimbursement program. All payments will be made to the **representative payee** as designated on SSI records. **Minors not receiving SSI benefits must have documentation of state or federal Determination of Disability to receive reimbursement.**

Eligibility for Reimbursement:

- A **signed**, approved application must be on file. A new application is to be submitted each fiscal year.
- Submission date of the application will be the date the application is received at the Tribal office.
- **ORIGINAL RECEIPT(s) (not copies)** must be sent to the tribal office, and be dated within the fiscal year of application date.
- All receipts must show date and amount of transaction with description of product(s) and services.
- All receipts must contain the vendors contact information and a detailed summary of product(s) and services.

Eligible Expenses:

Insurance and Taxes:

- Life Insurance
- Home Owner's Insurance
- Automotive Insurance
- Healthcare Insurance
- Personal Content Insurance for renters
- Property Tax

Note: ALL insurance/proof of ownership of property must be in the name of the eligible tribal member to qualify for payment.

Utilities:

- Electric
- Natural gas
- Propane
- Water
- Trash services
- Telephone services

Note: ALL utilities must be in the name of the eligible tribal member to qualify for payment.

Health Care Expense:

- Prescription eye glasses
- Dentures
- Medical Alert Service
- Prescription medication
- Health care deductibles
- Physician prescribed ambulatory product (wheelchair, cane, walker)
- Hearing aids
- Miscellaneous items prescribed by a physician

Note: ALL prescriptions and deductibles must be in the name of the eligible tribal member to qualify for payment.



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 _____