MANDAN, HIDATSA, ARIKARA ELDERS ORGANIZATION

Programs and Services for off Reservation Elders:

Updated October 15, 2019 BOD Mtg

PLEASE ACKNOWLEDGE THE CHANGES IN AMOUNTS THE ELDER'S ORGANIZATION IS ABLE TO HELP ELDERS OFF RESERVATION WITH; EFFECTIVE IMMEDIATELY

Based on availability of funds, the MHA Elder's Organization will provide financial assistance to all enrolled members 60 years of age and older off the reservation effective March 14, 2014, for the purposes described below:

I. **After all other resources are** exhausted such as IHS, Medicaid, Veterans Benefits, Vocational Rehab, private insurance etc. The Mandan, Hidatsa, Arikara Elder's Organization will financially assist the elders off the reservation as follows:

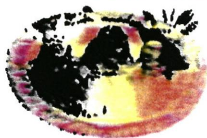
Glasses:	NTE	**$600.00**
Dentures/Dental Work:	NTE	**$4,000.00**
Hearing Aids:	NTE	**$4,000.00**

Payments for the above services will be paid directly to the vendor. All costs over and above these amounts will be the financial responsibility of the elder. The MHA Elder's Organization **does not** cover the costs of medical prescriptions and other medical bills.

To receive financial services off the reservation, Elders must contact the Executive Director, Maria Two Shields, at (701) 627-3506.
Or address to:

MHA Elder's Organization
P.O. Box 400
New Town, ND 58763
Fax: (701) 627-2954

PLEASE SUBMIT WORK TO INSURANCE BEFORE SENDING TO US, AS WE ARE A SECOND PAYEE. THE ELDER'S ORGANIZATION IS **NOT** AN INSURANCE COMPANY.



MHA ELDERS ORGANIZATION- Year 2016

710 E. AVE PO BOX 400 New Town, ND. 58763
701-627-3506 FAX: 701-627-2954

Segment: ____________________

Name:__________________________ **Maiden Name:**____________________

Date of Birth:_____/_____/_______ **Enrollment # :**____________________

Spouse Name:____________________ **Date of Birth:**______/_____/__________

Enrollment #:____________________ _**Insurance:**__________________________

Mailing Address:

PO Box:__________ **City:**____________________ **State:**______ **Zip Code:**______

Physical Address:__________________________ **Telephone#:**______________

IF APPLICABLE:

Other than spouse the following person listed. Is to act on my behalf, and authorized to pick up my check (s).

Name:__________________________ **Address:**__________________________

Telephone#:____________________ **Relationship:**__________________________

Check #_______________________

I certify all information listed is true and correct to the best of my knowledge. I understand the information provided is to be used to determine my eligibility to receive financial medical services. I hereby grant permission to MHA ELDERS ORGANIZATION to investigate the information herein.

Signature: __________________________ **Date:**____________________

Revised 05-2016