



Phone/Message# _____

Community: _____

Date Needed by: _____

CHEYENNE RIVER SIOUX TRIBE

MEDICAL ASSISTANCE APPLICATION

MEDICAID: YES: _____ NO: _____

Name: _____ DOB: _____ Age: _____

Address: _____ CRU#: _____

Applicant Monthly Income: _____ Amount: _____

Marital Status: _____ Household Size: _____ Ages: _____

Spouse: _____ Age: _____ Income: _____

Have you received assistance in the past 30 days? YES NO

Location of Appointment: _____

Date of Appointment: _____ Time of Appointment: _____

Meals: _____ Mileage: _____ Lodging: _____

Other: _____

Mode of Transportation: (MUST CHECK ONE): _____ Private Vehicle _____ IHS van _____ Transit _____

***Must attach appointment slip/verification**

I, hereby authorize the Cheyenne River Sioux Tribe to obtain any necessary information to assist my eligibility for medical assistance.

Applicant Signature _____

Date _____

Denial/Reason: _____

Approval: _____

Support Services Director

Amount _____