



Phone/Message# _____

Community: _____

Date Needed by: _____

CHEYENNE RIVER SIOUX TRIBE

MEDICAL ASSISTANCE APPLICATION

Name: _____ DOB: _____ Age: _____

Address: _____ CRU#: _____

Source of Income of Applicant: _____ Amount: _____

Marital Status: _____ No. of Dependents: _____ Ages: _____

Spouse: _____ Age: _____ Income: _____

Have you received assistance within 30 days? YES NO

Reason for Assistance: _____

***Must attach appointment slip**

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: _____
Corey Eagle Staff, Support Services Director Amount