MNICOUJOU ITAZIPCO

SIHA SAPA OOHENUMPA

Phone/Message#_____

Community:_____

Date Needed by:_____

CHEYENNE RIVER SIOUX TRIBE

MEDICAL ASSISTANCE APPLICATION

Name:_____DOB:_____Age:_____

Address:_____CRU#:_____

Residence Address:_____

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:_____

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

***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

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Denial/Reason:_____

Approval:_____ _____

Corey Eagle Staff, Support Services Director Amount