



Phone/Message# _____

Community: _____

Date Needed by: _____

CHEYENNE RIVER SIOUX TRIBE

MEDICAL ASSISTANCE APPLICATION

MEDICAID: YES: _____ NO: _____

Name: _____ DOB: _____ Age: _____

Address: _____ CRU#: _____

Physical Address: _____

Source of Income of Applicant: _____ Amount: _____

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

Spouse: _____ Age: _____ Income: _____

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

Assistance Requested: _____

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 _____

Denial/Reason: _____

Approval: _____

Corey Eagle Staff, Support Services Director

Amount