

Application for Johnson O'Malley (JOM) Program

CONFEDERATED TRIBES OF SILETZ INDIANS OF OREGON – EDUCATION DEPARTMENT
 PORTLAND AREA EDUCATION SPECIALIST, KATY HOLAND
 12790 SE STARK ST., STE. 102, PORTLAND, OR. 97233
 503-238-1512. FAX (503) 238-2436/EMAIL KATYH@CTSI.NSN.US

To qualify for the JOM program, your child must be a student and enrolled or eligible to enroll in a Tribe. If your child is not eligible or currently enrolled in a Tribe your child will not be eligible for the JOM Program.

STUDENT INFORMATION:

| | | | |
|---|------------|-------------------|---------------|
| LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH |
| | | | |
| MAILING ADDRESS | | CITY AND ZIP CODE | |
| | | | |
| RESIDENT ADDRESS (IF DIFFERENT THAN MAILING IF NOT LEAVE BLANK) | | CITY AND ZIP CODE | |
| | | | |
| COUNTY OF RESIDENCE | HOME PHONE | DAYTIME PHONE | MESSAGE PHONE |
| | | | |
| TRIBAL AFFILIATION | | ENROLLMENT NUMBER | BLOOD DEGREE |
| | | | |
| SCHOOL ATTENDING | | | GRADE |
| | | | |
| LIST ANY ILLNESS OR MEDICAL CONDITION THAT MAY AFFECT STUDENTS PARTICIPANT IN THE JOM PROGRAM | | | |
| | | | |

STUDENT'S PARENTS INFORMATION:

| | |
|---------------|----------|
| MOTHER'S NAME | TRIBE(S) |
| | |
| FATHER'S NAME | TRIBE(S) |
| | |

INFORMATION ON OTHER CHILDREN WHO RESIDE IN THE HOUSEHOLD:

| NAME | AGE | NAME | AGE |
|------|-----|------|-----|
| | | | |
| | | | |
| | | | |

EMERGENCY CONTACT INFORMATION:

| | |
|------------------------|-------------------------|
| NAME OF CONTACT PERSON | RELATIONSHIP TO STUDENT |
| | |
| STREET ADDRESS | TELEPHONE NUMBER(S) |
| | |

SIGNATURE OF PERSON COMPLETING THIS FORM:

X

SIGNATURE, RELATIONSHIP TO STUDENT

TODAY'S DATE

Office Only: Update Moved Graduated Dropped Out

Authorization for Release of Information

CONFEDERATED TRIBES OF SILETZ INDIANS OF OREGON – EDUCATION DEPARTMENT
SILETZ AREA EDUCATION SPECIALIST, ALISSA LANE
PO BOX 549; 201 SE SWAN AVE; SILETZ, OREGON 97380
1-800-922-1399 EXT 1373. FAX (541) 444-8392

To our clients: We can help you better if we are able to work with other agencies that know you and your family. By signing this "Authorization for Release of Information" form, you are giving permission for these organizations to share information about your situation.

| NAME OF STUDENT | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|-----------------|---------------|------------------------|
| | | |

I AUTHORIZE THE FOLLOWING INDIVIDUALS OR AGENCIES TO PROVIDE INFORMATION:

| | |
|----------------|-------|
| _____ | _____ |
| CTSI of Oregon | _____ |
| _____ | _____ |

INCLUDING RECORDS OF: Education Reports, Verification of eligibility for free and/or reduced lunch program, and Certificate of Indian Birth (CIB). Please note: Education records include both behavior and progress reports.

PURPOSE: The information received will be used to evaluate my situation and to plan for and coordinate services for my family and me, or for JOM services. This permission is good for one (1)-year from the date of signing.

I can cancel this at any time, but I understand the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by the state and federal law. I agree that the individuals and agencies listed above may share and exchange information about my family and my circumstances. I approve the release of this information. I understand that what this agreement means. I am signing this "Authorization of Release of Information" form on my own and have not be pressured to do so.

- Client Guardian
 Parent Legal Custody

 _____
SIGNATURE

DATE

For people who cannot read: I have read the form to the client. He/She understands this form and signed it voluntarily.

Print Name: _____ Signature: _____ Date: _____

Worker's Name: _____ Signature: _____ Date: _____

For people who cannot write: I understand this form and am completing it voluntarily. I cannot write. I am placing my mark by my name to sign this form.

My Mark: ➔ _____ Full Name of Client: _____

Witness #1: _____ Address: _____

Witness #2: _____ Address: _____

To those receiving information under this authorization: State and federal law protect this information disclosed to you. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.



Confederated Tribes of Siletz Indians
 12790 SE Stark St., Ste. 102
 Portland, Oregon 97233
 503-238-1512/FAX 503-238-2436/email katyh@ctsi.nsn.us

JOHNSON O'MALLEY (JOM) PROGRAM REQUEST FOR SERVICES

To qualify for services, the student must have a JOM application on file with the education department.

JOM Students' Name: _____

Update information for JOM file:

| | | | |
|---|--------------------|-----------------------------|--|
| Parent/Legal Guardian's Name (whom the student resides with): | | County of Residence: | |
| Mailing Address: | | City and ZIP Code: | |
| Home Telephone: | Daytime Telephone: | Message Telephone: | |
| Current School Attending: | Grade: | S.S. Number or Roll Number: | |

Information on Service Requesting:

Type of Service Requesting: Cultural Enhancement Parental Cost (shoes, sports fees, etc.)
 Preschool Assistance Tutoring (need tutoring forms)

REASON FOR REQUEST: _____

Approximate cost for this request: (some requests have a maximum not to exceed limit due to limited funds, please inquire if needed. -i.e. shoes not to exceed \$35.00): \$ _____

VENDORS NAME
 (store, company, etc): _____
 ADDRESS (if known): _____

If this is a Parental Cost request, please answer the following questions:

Is your child receiving free or reduced lunches at school? Yes No
 Are you receiving USDA Commodities or Food Stamps? Yes No

If you answered No to both questions above, please list your source and monthly income below:

Source of Income: _____ Monthly Income: _____

I certify that the above information is complete and accurate. I understand that any misinformation may lead to denial of services or benefits.

Signature of Parent/Legal Guardian _____ Date _____

For Office Use Only: Approved \$ _____
 Denied _____