

# Application for Johnson O'Malley (JOM) Program

CONFEDERATED TRIBES OF SILETZ INDIANS OF OREGON – EDUCATION DEPARTMENT  
EUGENE AREA EDUCATION SPECIALIST- NICK VILES  
2468 WEST 11<sup>TH</sup> AVE, EUGENE, OR 97402  
541-484-4234 FAX: 541-484-4583 EMAIL: NICKV@CTSI.NSN.US

To qualify for the Siletz Supplemental Education program, JOM, your child must be a current student at an eligible school and be enrolled in a federally recognized tribe or possess ¼ blood quantum. Please fill out this application completely submit it with a copy of the student's tribal enrollment card or CIB.

## STUDENT INFORMATION:

LAST NAME		FIRST NAME		PREFERRED 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	CELL PHONE		EMAIL ADDRESS			
TRIBAL AFFILIATION			ENROLLMENT NUMBER			BLOOD DEGREE	
SCHOOL ATTENDING						GRADE	
LIST ANY ILLNESS, ALLERGIES, OR MEDICAL CONDITION THAT MAY AFFECT STUDENTS PARTICIPANT IN THE JOM PROGRAM							

## PARENT/GUARDIAN INFORMATION:

PARENT/LEGAL GUARDIAN NAME		TRIBE(S)	
PARENT/LEGAL GUARDIAN 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

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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	STUDENT ID (IF KNOWN)

## I AUTHORIZE THE FOLLOWING INDIVIDUALS OR AGENCIES TO PROVIDE INFORMATION:

Linn, Benton and Lane County School districts

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. They understand 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 sigh 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.