Application for
Johnson O'Malley (JOM) Program

Select your local Education Specialist

☐ **Katy Holland**
Portland Area Office
12790 SE Stark Street, Suite 102
Portland, OR 97233
(503) 238-1512
katyh@ctsi.nsn.us

☐ **Alissa Lane-Keene**
Siletz Area
201 SE Swan Avenue P.O. Box 549
Siletz, OR 97380
(541) 444-8373
alissal@ctsi.nsn.us

☐ **Sonya Moody-Jurado**
Salem Area Office
3160 Blossom Drive NE, Suite 105
Salem, OR 97305
(503) 390-9494
sonyamj@ctsi.nsn.us

☐ **Candace Hill**
Eugene Area Office
2468 W. 11th
Eugene, OR 97402
(541) 484-4234
candaceh@ctsi.nsn.us

To qualify for the Johnson O'Malley (JOM) program, your child must be a public Head Start/Preschool - 12th grade student and enrolled in a federally recognized tribe. Please completely fill out this application and submit it with a copy of the student's tribal enrollment card or a CIB.

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

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Sonya Moody-Jurado
Salem Area Office
3160 Blossom Drive NE, Suite 105
Salem, OR 97305
(503) 390-9494
sonyamj@ctsi.nsn.us

Nick Viles
Eugene Area Office
2468 W. 11th
Eugene, OR 97402
(541) 484-4234
nickv@ctsi.nsn.us

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 _____ _____

School District (Write Above)

_____ _____

Name of Child's School (Write Above)

_____ _____

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.