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Suite 105
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(503) 390-9494

Candace Hill
Eugene Area Office
2468 W. 11th
Eugene, OR 97402
(541) 484-4234

Application for Johnson O'Malley (JOM) Program

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.
One Application for each eligible JOM Student.

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

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)

SCHOOL INFORMATION:

SCHOOL ATTENDING	GRADE

PLEASE SELECT ANY SERVICES YOUR CHILD MAY BE RECEIVING AT SCHOOL:

☐ 504 Plan ☐ IEP ☐ Intervention Services ☐ TAG ☐ Transitional Services

EMERGENCY CONTACT INFORMATION:

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

SIGNATURE OF PARENT/GUARDIAN (COMPLETING FORM):

X

SIGNATURE, _____ TODAY'S DATE _____

Office Only: ☐Update ☐Moved ☐Graduated ☐Dropped Out

Authorization for Release of Information

CONFEDERATED TRIBES OF SILETZ INDIANS OF OREGON – EDUCATION DEPARTMENT

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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 SCHOOL ID (IF KNOWN)

I AUTHORIZE THE FOLLOWING INDIVIDUALS OR AGENCIES TO PROVIDE INFORMATION:

CTSI of Oregon _____ _____

_____ Name of Child's 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. 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.