THE HOPI TRIBE

ADULT VOCATIONAL TRAINING PROGRAM
REQUIRED OFFICIAL DOCUMENTS

The following documents must be submitted before Eligibility for services is determined.

1. **Official Birth Certificate(s)** *(applicant and dependents)*
2. **Social Security Card(s)** *(applicant)*
3. **Tribal Enrollment Card** (*applicant*)
4. **Selective Service Registrant/Acknowledgement Letter** (*males, 18 to 26 years of age, born on or after January 01, 1960*) or **Military DD214**
5. **Official High School transcripts or GED Test Scores**
6. **Official Transcripts from Post Secondary and/or Vocational Schools**
7. **Marriages License or Divorce Decree**
8. **Statement of Medical Exam** *(Physical Exam form)*

For information call: (928)-734-3542 or 1-800-762-9630

THE HOPI TRIBE

ADULT VOCATIONAL TRAINING PROGRAM

Application

PART 1 –PERSONAL DATA

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

OTHER NAMES USED: _____

ADDRESS: _____ _____ _____ _____ _____

P.O. Box/Street Address | City | State | Zip Code | County

SOCIAL SECURITY #: _____ **BIRTHDATE:** _____ **AGE:** _____

RACE: ☐ WHITE ☐ HISPANIC ☐ BLACK ☐ NATIVE AMERICAN ☐ ASIAN ☐ PACIFIC ISLANDER

TRIBE: _____ **ENROLLMENT #:** _____ **GENDER:** ☐ **MALE** ☐ **FEMALE**

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORSED/SEPERATED ☐ WIDOWED

SELECTIVE SERVICE REGISTRATION #: *(For males 18 – 26 born on or after January 01, 1960)*_____

VETERAN STATUS: ☐ YES, More than 180 days ☐ YES, Less than 180 days ☐ NO

DO YOU ACKNOWLEDGE A DISABILITY? ☐ YES ☐ NO

PHONE NUMBER: _(___)_____**MESSAGE PHONE CONTACT** _(___)_____

E-MAIL ADDRESS: _____**MESSAGE PHONE CONTACT** _(___)_____

PART II – EDUCATIONAL DATA

HIGH SCHOOL ATTENED: _____

Month/Year Graduated: _____ If not a graduate, highest grade completed: _____

GED: Month/Year Obtained: _____ Testing Site: _____

NAME OF COLLEGE/UNIVERSITY ATTENDED (Most Recent): _____

Year Graduated: _____ Type of Degree Earned: _____ Major: _____

NAM E OF VOCATIONAL TRAINING ATTENDED (Most Recent): _____

Date Completed: _____ ☐ Certificate ☐ Diploma

ARE YOU CURRENTLY ENROLLED IN ANY SCHOOL/TRAINING INSTITUTION? ☐ Yes ☐ No

If yes, name & address of school attending: _____

_____

_____

PREVIOUSLY FUNDED? (If yes, please check which program and year) _____ Yes _____ No

☐ Adult Vocational Training Program (AVTP) (Year) _____ ☐ Grants & Scholarship Program (Year) _____

☐ WIA Program (formerly JTPA) (Year) _____

PART II – EMPLOYMENT DATA

LABOR FORCE STATUS: ☐ Employed ☐ Unemployed ☐ Underemployed

UNEMPLOYMENT STATUS: ☐ Claimant ☐ Exhaustee ☐ Neither

SEEKING WORK? ☐ Yes ☐ No

WORK HISTORY – LIST MOST RECENT JOB (Attach additional work history):

EMPLOYER: _____ JOB TITLE: _____

ADDRESS: _____ EMPLOYED: From: _____ To: _____

JOB DUTIES: _____

_____

HOURLY WAGE: _____ REASON FOR LEAVING: _____

PART IV – INCOME DATA

Does your family receive any of the following? (If yes, please check what type)

TANF (Cash Assistance)	☐ No ☐ Yes	**Social Security**	☐ No ☐ Yes
Food Stamps (FS)	☐ No ☐ Yes	**Child Support**	☐ No ☐ Yes
General Assistance (GA)	☐ No ☐ Yes	**Alimony**	☐ No ☐ Yes
Jobs Program Participant (JOBS)	☐ No ☐ Yes	**Employment (Wages or Self Employment)**	☐ No ☐ Yes

IN CASE OF EMERGENCY, PLEASE CONTACT

NAME: _____ **RELATIONSHIP TO APPLICANT:** _____

ADDRESS: _____ **HOME PH:** _____ **MESG. PH.:** _____

_____

BY MY SIGNATURE. I CERTIFY THAT THIS INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT ALL PROGRAMS UNDER THE DEPARTMENT OF EDUCATION SHALL HAVE ACCESS TO THIS INFORMATION FOR BUSINESS PURPOSE:

APPLICANT SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____
(IF APPLICANT IS UNDER THE AGE OF 18)

***** OFFICE USE ONLY*****

REFERRAL TYPE: _____

REFERRAL TO: _____ **REFERRAL FROM:** _____

STATUS: _____ **STAFF:** _____

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Statement of Medical Examination

(To be completed by Physician)

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

MEDICAL HISTORY

Disease	When Diagnosed	Treatment	Resolved Chronic or Frequent Occurrence(s)
Hypertension			
Diabetes			
Heart Disease			
Kidney Disease			
Tuberculosis			
Seizures			
Anxiety/Nervous Reactions			
Ulcers/Gastritis			
Respiratory Infections			
Gastroenteritis			
Ear Infections			
Alcoholism			
Musculoskeletal			
Sexually Transmitted Disease			
AIDS			
Other			

COMMENTS: _____

_____

IMMUNIZATIONS:

DPT: _____ OPV: _____

DT: _____ MMTR: _____ PPD: _____

Current Medications: _____

_____

WILL THIS PERSON NEED:

	YES	NO
1) Follow up for Med. /Surg. Problems?	_____	_____
2) Glasses?	_____	_____
3) Dental Work?	_____	_____
4) Immunizations?	_____	_____
5) Hearing Problems	_____	_____

PHYSICAL EXAM:

WT: _____ HT: _____ B/P: _____ VISION: _____

HEARING: NORMAL: _____ ABNORMAL: _____

	NORMAL	ABNORMAL
HEENT		
Neck		
Thorax		
Breast Axiillae		
Lungs		
Heart		
Abd.		

	NORMAL	ABNORMAL
Extremities		
Musculoskeletal		
Spine		
Skin		
Genitalia		
Neurological		
Medical Status		

If abnormal, please explain: _____

LAB: HCT UA

OB/GYN hx: **P.** _____ **G.** _____ **Pap** _____

COMMENTS: _____

ALLERGIES, FOOD SENSITIVITY: _____

SERVICE UNIT: _____ MD SIGNATURE: _____ DATE: _____