DIRECT EMPLOYMENT
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 and dependents)*
3. **Tribal Enrollment Card** (*applicant and dependents*)
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 Transcript or GED Test Scores**
6. **Official Transcript from Post Secondary and /or Vocational Schools**
7. **Marriage License or Divorce Decree**
8. **Certificate/Diploma/Degree**
9. **Verification of Employment** *(applicant)*
10. **Statement of Medical History**

Revised: DT 8/2/16

ADULT VOCATIONAL TRAINING PROGRAM
Direct Employment Application

PART I – PERSONAL DATA

Name: ____________________________________ *SSN:* ____________
Last *First* *MI*

DOB: ______________ *Enrollment #:* ______________ *Village Affiliation:* ______________

Marital Status: _____ *Single* _____ *Married* _____ *Divorced* _____ *Separated* _____ *Widowed*

# of Legal Dependents: __________ *Ages:* __________ *# of children in school:* __________

Mailing Address: ____________________________________ ( ) ____________
P.O. Box *City* *State* *Zip Code* *Phone Number*

Emergency Contact: ______________________ *Phone Number:* ( ) ____________

PART II – EDUCATIONAL DATA

*Have you been previously been funded by **DE**?* ( ) *Yes* ( ) *No* *If yes, year funded:* __________

High School Attended: ______________________ *Year Diploma/GED Rec'd:* __________

Please list all post-secondary schools attended (use additional page if necessary)

School Attended	*City/State*	*Sem/Yr. Attended*	*Credits Earned*
School Attended	*City/State*	*Sem/Yr. Attended*	*Credits Earned*

PART III – EMPLOYMENT DATA

EMPLOYMENT HISTORY (List your three most important period of employment)

1. *From:* __________ *To:* __________ *Employer Name & Address* __________
   Job Title: __________ *Description of Duties:* __________
   Reason for Leaving: __________

2. *From:* __________ *To:* __________ *Employer Name & Address* __________
   Job Title: __________ *Description of Duties:* __________
   Reason for Leaving: __________

3. *From:* __________ *To:* __________ *Employer Name & Address* __________
   Job Title: __________ *Description of Duties:* __________
   Reason for Leaving: __________

(OVER →)

PRIVACY ACT AND PAPERWORK REDUCTION ACT STATEMENT:

1. *The authority for solicitation of the information on this form is 25 U.S.C. 13 (43 Stat. 208) and P.L. 84-959 (70 Stat. 986) as amended by P.L. 88-230 (77-Stat. 471, 25 U.S.C. 309).*
2. *Disclosure of request information by the applicant is required to be considered for services*
3. *The purpose of this information collection is to determine your eligibility for services.*
4. *The purpose of this information is to be used by the Hopi Tribe AVTP and training institutions*

FORMAL REQUEST

I hereby apply to the Hopi Tribe Adult Vocational Training Program (AVTP) for Direct Employment (DE) services and agree to fully cooperate with those officials designated to render this service. Therefore, financial assistance for this purpose is being formally requested. Upon my eligibility for DE Funds, I agree to provide required receipts within two weeks after receipt of funds and agree that the funds issued to me for DE purposes by the AVTP shall be used for this specific purpose or repayment shall be made to the Hopi Tribe AVTP.

I acknowledge that I read, understand and agree to abide by the conditions of this award. I hereby provide the required information and authorize the use of such information to the extent of the uses specified in the statement.

______________________________ ________________

SIGNATURE OF APPLICANT *DATE*

ADULT VOCATIONAL TRAINING PROGRAM
STATEMENT OF MEDICAL HISTORY

NAME: (LAST, FIRST, MIDDLE)	DATE OF BIRTH:	TRIBE:
HOME ADDRESS:	TYPE OF SERVICE: _____ Adult Vocational Training Program _____ Direct Employment Program	

HAVE YOU EVER HAD, OR HAVE NOW: (Please check off each item which pertains to you)

YES	NO		YES	NO	
		Poor vision in one or both eye			Paralysis
		Eye Disease (Describe type below)			Arthritis, Rheumatism, Swollen or Painful Joints
		Poor hearing in one or both ears			Respiratory Infection
		Diabetes			Loss of Hand, Arm, Foot or Leg
		Palpitation (Chest Pain or Shortness of Breath)			Deformity of Hand, Arm, Foot or Leg
		Rapid heart beat			Nervous or Mental trouble of any kind
		Heart Disease			Seizures (Blackouts or Epilepsy, Fits or Spasms)
		Dizziness of Fainting Spells			Sugar or Albumin in Urine
		Frequent or Severe Headache			Drinking of Alcohol (Occasional, Moderate, Frequent)
		Hypertension (high/low Blood Pressure)			Kidney Disease
		Drug or Narcotic Habit			Hernia
		Venereal Disease			Ulcers/Gastritis/Gastroenteritis
		Chronic or Frequent Colds			Denial of Life Insurance
		Sinusitis			Refusal of, or Separation from Employment
		Tumor, Cyst, Cancer			Because of your health, Rejection from Military
		Loss of Memory of Amnesia			Service for Physical, Mental or Other
		Tuberculosis			Have you had or been advised to have any operations?
		Goiter			Do you wear glasses?
		Hemorrhoids			Do you wear a Hearing Aid?
		Have you consulted or been treated by Clinics, Physicians, Healers or other Practioners within the past 3 years? If so, where? ______________			AIDS

IF YOUR ANSWER IS "YES" TO ANY OF THE ABOVE, EXPLAIN EACH IN THE SPACE BELOW:

____

____

____

____

____

WHERE ARE YOUR HOSPITAL RECORDS AND X-RAYS? ______________________________

FEMALES ONLY: Are you pregnant now? ______________

I CERTIFY THAT MY ANWERS ABOVE ARE FULL AND TRUE:

APPLICANT SIGNATURE: ______________________ **DATE;** ______________

COUNSELOR'S SIGNATURE: ______________________ **DATE:** ______________

ADULT VOCATIONAL TRAINGING PROGRAM

DIRECT EMPLOYMENT

Applicants who apply and are determined eligible for program services may be provided financial assistance for one month or until the first full paycheck is received. Verification of employment is required by providing the following information.

1. Position Title
2. Starting Date
3. Starting Salary
4. First Pay Date
5. First Full Pay Date
6. Statement from the employer that the position is anticipated to be of a permanent nature.

The Direct employment Counselor will monitor the participant on a regular basis up to (6) months from the date of entry into employment.

Revised 2/10