## Income Guidelines for JOM & Adult Ed.

Family size and income Eligibility scale for assistance*

| Family size | Maximum Yearly Income |
|---|---|
| 1 | $ 9,213 |
| 2 | 12,432 |
| 3 | 15,651 |
| 4 | 18,870 |
| 5 | 22,089 |
| 6 | 25,308 |
| 7 | 28,527 |
| 8 | 31,746 |
| Each Additional Family Member | 3,219 |

*Special Circumstances will be considered regarding income eligibility for assistance.

### *ADULT EDUCATION*

*Adult education is for the enhancement of job-related skills and to further adult basic education. The Johnson O'Malley adult education program has the ability to help those who need financial and educational assistance in obtaining their personal/educational goals. If you would like more information on our program please feel free to call 444-4263.*

*Thank you,*
*Rena Philbrook*
*Education Specialist*

**APPLICATION FORM**
**JOHNSON O'MALLEY PROGRAM**

Student Name_____Date_____

Address_____

County of Residence_____Home Phone_____

Date of Birth_____Message Phone_____

Roll #_____or Blood Degree_____

Tribal Affiliation(s)_____

School Attending_____Grade_____

School Address_____

Mother_____Roll #_____

Father_____Roll #_____

Student Resides with: (Name & Relationship)

_____

EMERGENCY CONTACT INFORMATION: In case of an emergency,

Please contact:_____

Name_____Relationship_____

Street Address_____Phone_____

_____

PLEASE LIST ANY ILLNESSES OR MEDICAL CONDITIONS THAT MAY AFFECT STUDENT PARTICIPATION IN THE JOM PROGRAM:_____

_____

Please list other children in the household: (Name & Age)

Confederated Tribes of Siletz

ADULT EDUCATION APPLICATION

Please Complete All Sections

Name of Applicant_____Age_____

Roll#_____Phone_____Msg. Phone_____

Address_____

Social Security #_____

Class Requested (Title)_____

_____

Name and Address of School, Organization or person offering this class:

_____

_____

Please list all required costs of enrolling in this class:

Tuition or Fees $_____

Books/Supplies $_____

Other Costs $_____

Total $_____

List all other required costs:

Applicants Signature_____Date_____

FOR OFFICE USE ONLY

_____APPROVED_____DENIED_____AMOUNT

_____

SIGNATURE DATE TITLE

SURVEY

SUBJECT: CATERING SERVICE IN SILETZ OREGON

IF YOU WERE TO HAVE A CATERING SERVICE IN SILETZ DELIVERING FOOD AND DRINK IN THE MORNING AND THE AFTERNOON WOULD YOU BE INTERESTED?
YES ___ NO ___

IF SO PLEASE INDICATE WHAT YOU WOULD WISH TO BE AVAILABLE ON BOTH THE MORNING MENU AND THE AFTERNOON LUNCH MENU.

| MORNING MENU | LUNCH |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |

PLEASE RETURN TO SHARON RlCKETTS AT THE HEALTH CLINIC. THANKS.