

**LOW MOUNTAIN CHAPTER
SCHOLARSHIP PROGRAM
CHECK LIST**

- _____ 1. **APPLICATION-** Print legible and complete all appropriate information.
- _____ 2. **LETTER OF ADMISSION:** Must be from the admissions department of the Institution. Enrollment Verification is required for continuing students who have already submitted their Letter of Admission with the same Institution.
- _____ 3. **VOTER REGISTRATION CARD:** A copy or verification from the Navajo Nation Election Administration Office is valid.
- _____ 4. **CERTIFICATE OF INDIAN BLOOD (C.I.B):** Required for all applicants.
- _____ 5. **SOCIAL SECURITY CARD:** A copy of the card is required.
- _____ 6. **STUDENT CONSENT TO RELEASE INFORMATION:** Is required to release your confidential information to your school and/ or other individuals requesting for information. Exhibit B is optional and Exhibit C is required.
- _____ 7. **COLLEGE TRANSCRIPT:** Official transcript must be shown then a copy will be made and attached to the application by the administrative staff.

NOTE: If mailing your application packet it must be post marked by the deadline dates. The mailing address is P.O. Box 4416 Blue Gap AZ 86520. Any application post marked after the deadline date will not be considered. If you have any questions, please call 928-725-3700 or 3701.

**LOW MOUNTAIN CHAPTER
SCHOLARSHIP PROGRAM APPLICATION**

Low Mountain Chapter
Post Office Box 4416
Blue Gap, Arizona 86520
Telephone: 928-725-3700

Term(s) Applying For:
20__ Fall Semester-Due Aug. 30
20__ Spring Semester-Due Jan. 30
20__ Summer Session(s)-Due May.30

A NEW APPLICATION IS REQUIRED FOR ALL
NEW REQUESTS WITH THE SCHOLARSHIP

PERSONAL AND FAMILY DATA

SSN:	C#:	Applicant Name: (Last)	(First)	(M.I)	(Maiden Name)
Mailing Address: (If mailing address changes, please contact LMC immediately & provide new address)					Telephone No(s):
Permanent Home Address: City/ State/ Zip Code					E-mail Address:
Date of Birth:	Sex: F () M ()	Marital Status:	Spouse's Name:	No. of Dependent(s):	
Are you a Veteran? Y () N ()		Are you <u>currently</u> registered with Low Mountain Chapter? Yes () No ()			
		Date of registration: __/__/__			
Mother's Name:	Address: City/ State/ Zip Code			Chapter Affiliation:	
Father's Name:	Address: City/ State/ Zip Code			Chapter Affiliation:	
Name of Contact Person: (In case we are unable to contact you immediately)				Telephone No(s):	

EDUCATION DATA

High School/ G.E.D Center: (Name, City, State, Zip Code)	H.S Diploma or G.E.D received Month/ Year:
College Classification: Freshman: () Sophomore: () Junior: () Senior: () Graduate: () Post-Graduate: ()	
Training Institution, College or University you will attend:(Name, City, State, Zip Code)	Letter of Acceptance: Y () N ()
Type of Degree you are seeking: Diploma/Certificate () Associates: A.A., A.S., A.A. () Bachelors: B.A./B.S. () Masters: M.A./M.S. () Doctorate: Ed.D/M.D./Ph.D./J.D. ()	Anticipated Date of Graduation:
Name of Institution, College or University last attended:	Month & Year:
If Yes, When?	Institution:
Have you received Chapter Assistance Before? Yes () No ()	
Amount of Request:	
Purpose of Request:	

I certify that the information provided is correct to the best of my knowledge.

Applicant (SIGNATURE)

DATE:

DATE:	STATUS:	AWARD:	FALL	WINTER	SPRING	SCHOOL	TERM	INITIAL	INITIAL

Revised 05/09/08

**LOW MOUNTAIN CHAPTER
SCHOLARSHIP PROGRAM**

STUDENT CONSENT TO RELEASE INFORMATION

Low Mountain Chapter requires you written authorization to release your confidential information. The requirement is in compliance with the Privacy Act of 1974 (Public Law 93-579) to protect and control the Federal Government's collection and dissemination of personal information on individual citizens. The Act does not allow any person(s) to have access to an individual's information without consent, therefore, to authorize release of any information to person(s) other than yourself; you must provide consent in writing.

This form will allow you to designate certain individual(s) to have access to your Low Mountain Chapter files or records. You can limit the amount of information we can release to those individual(s). Please complete and return the following information to Low Mountain Chapter Office with your application. This form will only be used for the semester(s) you are applying for.

Applicant's Name:	Social Security Number:
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I authorize the following individual(s) to have access to Chapter Student Financial Assistance folder to make inquiries on my behalf regarding my application status and eligibility. (Please Print)

1. _____ Full access _____ *Limited access _____
2. _____ Full access _____ *Limited access _____
3. _____ Full access _____ *Limited access _____

***Limited access only** – Please specify below what access the individual is limited to:

Applicant's Signature:	Date:
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This Form will allow you to authorize _____ to release confidential information to Low Mountain Chapter to determine your eligibility for assistance with the Chapter Scholarship Program. You can limit the amount of information you want release to Low Mountain Chapter. Please complete and return the information to Low Mountain Chapter. This form will only be used for the semester(s) you are applying for.

Applicant's Name:	Social Security Number:
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I authorize the following office(s)/ school to release the following information to Low Mountain Chapter Administration to determine my eligibility for Chapter Student Financial Assistance Program. (Please Print)

Name of Office(s)/ School	Type of information to be release
1. _____	Full access _____
2. _____	Full access _____
3. _____	Full access _____

Applicant's Name:	Date:
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