ESEA (Title I) Income Eligibility

The Arizona Department of Education provides the following FY 2022 Income Guidelines for determining eligibility information for federal funding associated with programs funded under the Elementary and Secondary Education Act (ESEA).

Is your family at or below the current income guidelines based on the attached **ESEA (Title I) Income Eligibility Guidelines** schedule?

Indicator 1 ☐ Indicator 2 ☐ No ☐

Definition of Income: all items such as wages and salaries before any deductions, and other income, such as self employment, welfare, social security, retirement benefits unemployment compensation, worker's compensation, Aid for Dependent Children, alimony, child support, pensions, insurance or annuity payments, etc.

If your family qualifies, please complete the following information for each child:

Child's Name	Name of School	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that all the above information is true and correct.

Parent/Guardian Signature _____ Date: _____

These survey forms should be retained by the school or LEA and kept on file for a period of 5 years.

ESEA (Title I) INCOME Eligibility GUIDELINES

July 1, 2021- June 30, 2022

Income Eligibility 1

HOW OFTEN INCOME WAS RECEIVED

Family Size:	Yearly	Monthly	2 x Month (Bi-Monthly)	Bi-Weekly (Every Two Weeks)	Weekly
1	16,744	1,396	698	644	322
2	22,646	1,888	944	871	436
3	28,548	2,379	1,190	1,098	549
4	34,450	2,871	1,436	1,325	663
5	40,352	3,363	1,682	1,552	776
6	46,254	3,855	1,928	1,779	890
7	52,156	4,347	2,174	2,006	1,003
8	58,058	4,839	2,420	2,233	1,117
Each Additional Member Add:	+5,902	+492	+246	+227	+114

Income Eligibility 2

HOW OFTEN INCOME WAS RECEIVED

Family Size:	Yearly	Monthly	2 x Month (Bi-Monthly)	Bi-Weekly (Every Two Weeks)	Weekly
1	23,828	1,986	993	917	459
2	32,227	2,686	1,343	1,240	620
3	40,626	3,386	1,693	1,563	782
4	49,025	4,086	2,043	1,886	943
5	57,424	4,786	2,393	2,209	1,105
6	65,823	5,486	2,743	2,532	1,266
7	74,222	6,186	3,093	2,855	1,428
8	82,621	6,886	3,443	3,178	1,589
Each Additional Member Add:	+8,399	+700	+350	+324	+162

Note:

If all income is received on the same schedule
Example: alimony = $100 / month & pension = $300 / month
DO NOT use conversion factors

If family reports income sources from more than one schedule
Example: alimony = $100 / month & pension = $300 / week
Income MUST be converted to yearly.

Yearly Income = Monthly	x 12
Yearly Income = Twice Per Month (Bi-Monthly)	x 24
Yearly Income = Every Two Weeks (Bi-Weekly)	x 26
Yearly Income = Week	x 52

DO NOT round the values resulting from each conversion

Updated May 2021

Arizona Department of Education
Health and Nutrition Services

Medical Statement for Students with Special Dietary Accommodations

This form is used to request Dietary Accommodations in the U.S. Department of Agriculture (USDA) Child Nutrition Programs such as the National School Lunch Program, School Breakfast Program, Afterschool Snack Program, and Summer Food Service Program.

Part 1: To be completed by a parent/guardian

Child's Name: _____ Birth Date: _____

School Name: _____ Child's Grade: _____

Student ID #: _____

Parent/Guardian Name: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Parent/Guardian Signature: _____

Arizona Department of Education
Health and Nutrition Services

Part 2: To be completed by state licensed healthcare professionals*

*For purposes of Child Nutrition Programs, only a "Licensed Healthcare Professional" is permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs. The seven medical professionals listed are permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs administered in Arizona. (HNS# 11-2015). Dentists, Homeopathic Physicians, Naturopathic Physicians, Nurse Practitioners, Osteopathic Physicians, Physician Assistants, and Physicians.

A. List of foods/ingredients to be omitted from the diet.

B. Provide a brief explanation of how exposure to the food affects the child.

C. List of foods/ingredients that can be substituted into the diet to accommodate the dietary restrictions.

☐ This medical statement is **permanent**.
(This medical statement will remain in effect during the time the student is enrolled. A new medical statement will be required to change any aspect of information provided in this medical statement.)

☐ This medical statement is **temporary**.
(This medical statement will remain in effect for the current school year. A new medical statement will be required annually.)

Licensed Healthcare Professional Name: _____

Office Phone Number: _____

Licensed Healthcare Professional Signature: _____

Date: _____

DILCON COMMUNITY SCHOOL, INC.
HC 63, Box G
Winslow, Arizona 86047

PARENTAL CONSENT FOR ANNUAL ASSESSMENT/EVALUATION/EXAMINATION

This is to certify that I, _____, hereby agree to allow my child/ward, _____ to receive assessment(s), examination(s), or evaluation(s), as deemed necessary during the school year in the interest of furthering my child's education or educational placement.

PRE-PRESENTATIVE EXAMPLE OF TESTING THAT MAYBE ADMINISTERED

TYPE	AGENCY/PRACTITIONER
1. Arizona English Language Learner Assessment (AZELLA) K-8	Teachers
2. Partnership for Assessment of Readiness for College & Careers (PARCC) 3rd-8th	Teachers
3. North Western Evaluation Assessment (NWEA) K-8	Teachers
4. Arizona Instrument to Measure Students (AIMS-Online) 4th & 8th	Teachers
5. Dynamic Indicators of Basic Early Literacy Skills (DIBELS) K-6	Teachers
6. Oral Dine Language Assessment K-8	Culture Teachers
7. Vision, Hearing, & Speech Screenings	School Staff/Speech Therapist

The above services have been fully defined and explained to me and I am satisfied with the explanation of why these services may be necessary as presented by:

Name:_____ Principal:_____

I hereby certify that I have been advised of my rights to inspect all relevant educational assessment records pertaining to my child, to question such records, and to obtain copies of them. I further understand that I have the right to obtain an independent evaluation of my child and to request an impartial due process regarding the evaluation in case of disagreement.

I further understand that neither my child/ward's name nor my name will be used in any form that will violate our rights to privacy, confidentiality, or anonymity and that if the results of the assessment(s) are negative that all records be destroyed. I also understand that I will be advised of any assessment(s) given to my child and will be afforded the opportunity to review them and participate in the placement of my child as well as the development of the individual educational plan.

Signature:_____ Date:_____

Interpretation: ***Was*** ☐
Was not ☐

Witnessed:_____ Date:_____

I, undersigned, have defined and fully explained the proposed assessment(s) and explained why assessment(s) is necessary.

Signature:_____ Date:_____

D-77A | **DAY STUDENT CHECKOUT AUTHORIZATION** SY2021-2022

Student's Name: _____

I, the undersigned herein authorize the persons named below to check my child out of Dilcon Community School, Inc. I understand that by this authorization, I do fully and completely relieve the School and School Officials of all responsibility regarding my child. It is further understood those parents listed below are authorized to check my child out of school.

Please list the ***Name and Relation*** of the people authorized to check out your student.

AUTHORIZED

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

RESTRICTED

1	
2	
3	
4	
5	

PARENT OR LEGAL GUARDIAN X: _____

Dilcon Community School, Inc.

HC 63, Box G, Winslow, Arizona 86047 - Phone: (928) 657-3211 - Fax: (928) 657-3213

RELEASE / TRANSFER OF RECORDS

Student:_____ Grade: _____ DOB:_____

Parent/Legal Guardian:_____

This is a request that the records of the above named student be released from your facility for the purpose of a routine school transfer, educational planning and placement.

_____
Name of Previous School, Organization or Agency

_____
Post Office or Street Address

_____
City, State, Zip Code

The following records are authorized by the Parent/Legal Guardian to be released or transferred upon the receipt of this request:

_____ Official Withdrawal Slip

_____ Cumulative School Record

_____ Progress Monitoring Records (DIBELS, NWEA, PARCC, etc.)

_____ Response to Intervention, Child Study Team Referrals and Records, if any

_____ Psychological and Special Education Records
(If applicable to this student: Please include IEP, Consent for Evaluation, Placement, Summary Records.)

_____ Medical and Health Records, if any (including Birth and developmental history records, vision & hearing records.)

_____ Other:_____

I hereby authorize the release or transfer of the above records to:

Dilcon Community School
ATTN: ENROLLMENT OFFICE
HC-63, Box G
Winslow, AZ 86047
(928) 657-2310 FAX: (928) 657-3213

_____ _____
Parent/Legal Guardian ***Date***

BIA Form 6248
OMB No. 1076-0122
dcs/rev. 05/24/2021
Exp. 06/30/2022

Grade Level: KG/1st/2nd/3rd/4th/5th/6th/7th/8th
Boarding: _____
Day-Bus: _____

Bureau of Indian Education
DILCON COMMUNITY SCHOOL, INC.
Student Enrollment Application

SY2021-2022

Entry Date:

Withdrawal Date: _____

Native American Student Information System (NASIS) ID NO.

Student Name: LAST	First	Middle:	Gender:		Date of Birth:	Enrollment Number:	Degree of Indian Blood:
			Female:	Male:			

Student Address:	City:	State:	Zip Code:	Birth Place:	Tribal Affiliation:	Chapter Affiliation:
					Navajo	

Home Location:	Language most Spoken at Home:		Language most Spoken by Student:	
	Navajo:	English:	Navajo:	English:

With whom does the student live?	Did student participate in English Language Learn ELL?	Did student participate in Special Education?
Both Parents Father Mother Grandparents Guardian Other	**Yes/No**	**Yes/No**

Guardianship or Custodial issues must include proper notarized/court documentation, unless we receive copies that assigns custody to one parent, we must assume that both parents can visit/parents can visit/pick up the student from school. Who has legal guardianship of the student?

Father:	Tribal Affiliation:	Mother:	Tribal Affiliation:
Address (city,state,zip):		Address (city,state,zip):	
Home Location:		Home Location:	
Home Phone:	Work Phone:	Home Phone:	Work Phone:
Email:	Cell/Pager:	Email:	Cell/Pager:
Employer:	Census No:	Employer:	Census No:
Contact Allowed: **Y/N**	Received student mailings? **Y/N**	Contact Allowed: **Y/N**	Received student mailings? **Y/N**
Guardian Name:		Contact Allowed: **Y/N**	Received student mailings? **Y/N**
Address (city,state,zip):		Home Location:	
Home Phone:	Work Phone:	Cell/Pager:	Other:
Employer:		Email:	
Emergency Information: (other than parent/guardian):		Emergency Information: (other than parent/guardian):	
Relationship to Student:	May Pick up Student? **Y/N**	Relationship to Student;	May Pick up Student? **Y/N**
Home Phone:	Work Phone:	Home Phone:	Work Phone:
Cell/Pager:	Other:	Cell/Pager:	Other:

BIA Form 6248
OMB No. 1076-0122
dcs/rev. 05/24/2021
Exp. 06/30/2022

SCHOOL HISTORY:

For students whose last academic year was 8th grade:

Name of School: _____ Address: _____

Phone Number: _____ Grade Completed: _____ Dates Attended: _____

List all schools you have attended:

Previous School Attended: Dilcon Community School, Inc. Address HC 63, Box G Winslow, AZ 86047 Phone No. (928) 657-3211

Reason for transferring: _____ Grade Completed: _____ Dates Attended: SY2020-2021

Previous School Attended: _____ Address _____ Phone No. _____

Reason for transferring: _____ Grade Completed: _____ Dates Attended: _____

Has the student ever been removed or is the student in the process of being removed from a previous school due to disciplinary action? ***Yes/No (circle one)*** .

I am legally responsible for this student and hereby apply for his/her admission to Dilcon Community School, Inc. I understand that additional may be required by the school before this student is officially enrolled.

I recognize that this is a public document and that falsification of information on this document may constitute violation of the criminal laws. I further hereby certify the information contained herein is true and correct. I understand that any legal update of the information on this enrollment form is my responsibility.

_____ _____ _____

Print name of Parent/Legal Guardian ***Signature of Parent/Legal Guardian*** ***Date***

OFFICIAL USE ONLY	***Verified by:***

I certify that the above named student is enrolled member with the Navajo Tribal Indian Census as being of:

_____ **Degree of Indian Blood.** _____ **Enrollment/Census Number.** _____ **Agency.**

APPROVAL OF SCHOOL APPLICATION: _____ **Approved** _____ **Not Approved**

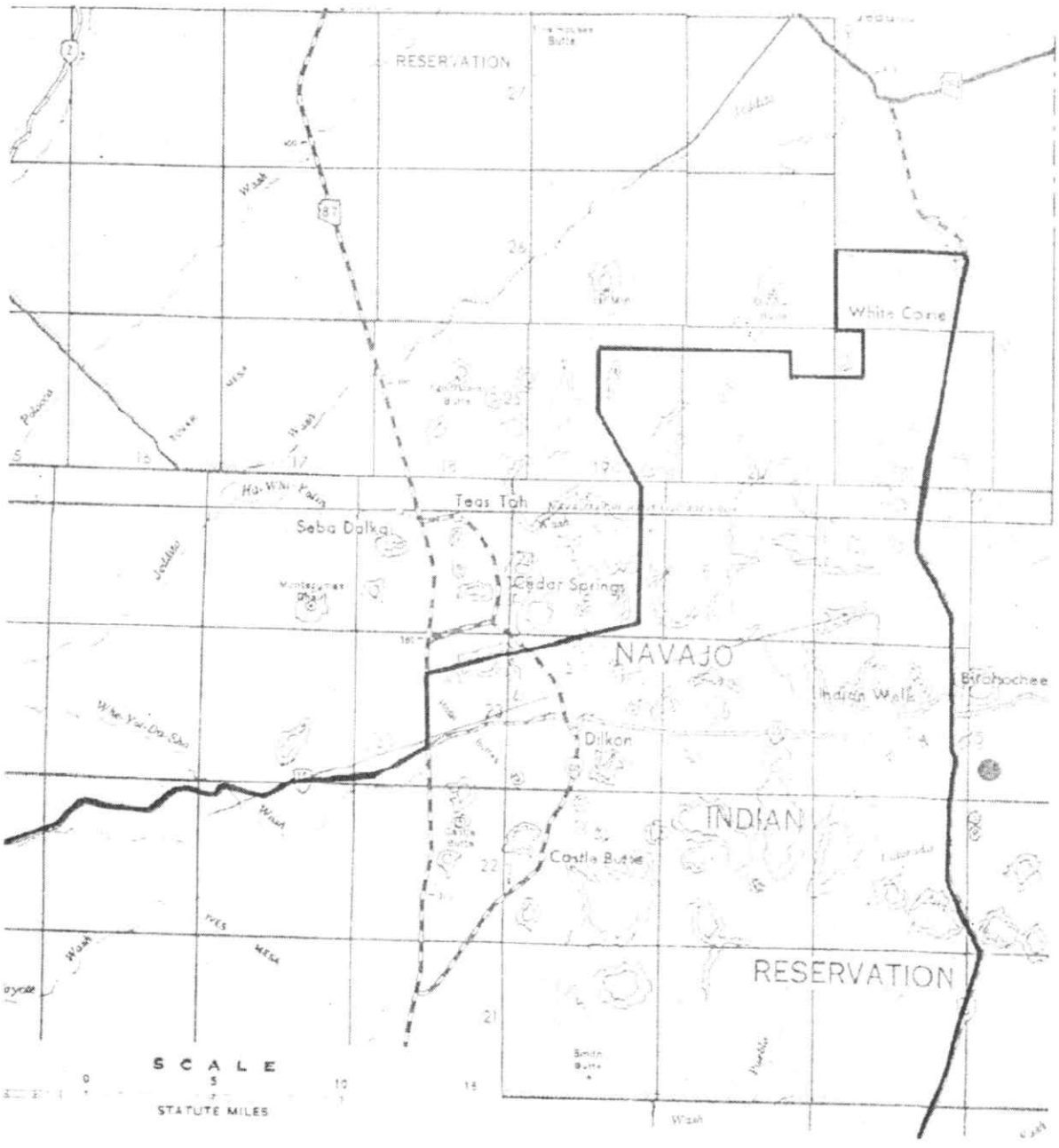
_____ _____ _____ _____

Signature of Principal or Registrar *Date* *Signature of Programs Support Assistant* *Date*

D-205 **Census Area Map-Dilcon**

I understand that all of the information is true and correct for _____.
I understand that this information is being furnished for the receipt of Federal funds, that school officials may verify the information on the application, and that deliberate misrepresentation of this information may subject me to prosecution under applicable State and Federal laws.

SIGNATURE OF PARENT OR ADULT FAMILY MEMBER DATE



Physical Location:

Dilcon Community School, Inc.

HC 63, Box G, Winslow, Arizona 86047 - Phone: (928) 657-3211 - Fax: (928) 657-3213

PARENTAL/GUARDIAN CONSENT FOR SCHOOL HEALTH SERVICES

Full Name of Student:_____ DOB:_____

Social Security #:_____ School: Dilcon Community School, Inc.

I,(We),_____

Authorize Dilcon Community School, Inc., to arrange for/or to provide the following health services for my child while he/she is attending school and/or the dormitory:

1. Health care including medical examination, routine laboratory studies, x-ray procedures, and skin tests.
2. Dental care including dental examinations, preventive use of fluorides and sealants necessary routine & emergency dental care.
3. Mental health services including evaluation and treatment as necessary.
4. Emergency health care for accidents or illnesses.
5. Transportation of the child and/or from another health care facility for these services.

____ I hereby give consent for all of the above services.

____ Exceptions or Special Instructions: _____

_____

_____

Print Name:_____

Signature:_____

Address:_____

Relationship:_____

For School Year: 2021-2022

PLEASE RETURN THIS FORM TO THE SCHOOL

WIHCC
Hózhóójí Áóó k'é

WINSLOW INDIAN HEALTH CARE CENTER

DATABASE

NAME (LAST, FIRST, MIDDLE)		OTHER NAMES USED(MAIDEN NAME)	WIHCC NO.	SEX M F
BIRTH DATE	PLACE OF BIRTH (CITY, STATE)	SOCIAL-SECURITY NO.	MARITAL STATUS	INTERNET Y N Email Address:
CURRENT COMMUNITY	DATE MOVED	LOCATION OF HOME (DIRECTIONS TO YOUR HOME, ETC. PLEASE BE SPECIFIC.)		
MAILING ADDRESS		CITY/STATE	ZIP CODE	
HOME PHONE NUMBER	MESSAGE PHONE NUMBER	WORK PHONE NUMBER		
INDIAN BLOOD QUANTUM	TRIBE	DEGREE	CENSUS NUMBER	CIB Y N
	OTHER TRIBE	DEGREE	RELIGION	
FATHER'S NAME	CITY OF BIRTH	STATE OF BIRTH		
MOTHER'S MAIDEN NAME	CITY OF BIRTH	STATE OF BIRTH		
EMPLOYER(IF APPLICABLE)		SPOUSE'S EMPLOYER(IF APPLICABLE)		
EMPLOYER'S ADDRESS		SPOUSE'S EMPLOYER'S ADDRESS		
EMPLOYER PHONE NUMBER		SPOUSE'S EMPLOYER PHONE NUMBER		
IF YOU ARE UNEMPLOYED, PLEASE GIVE SOURCE OF INCOME ___UNEMPLOYMENT ___RETIREMENT ___SSI ___SSB WELFARE OTHER				
NAME OF EMPLOYER (FATHER)18 & UNDER	EMPLOYER ADDRESS	EMPLOYER TELEPHONE NUMBER		
NAME OF EMPLOYER (MOTHER)18 & UNDER	EMPLOYER ADDRESS	EMPLOYER TELEPHONE NUMBER		
EMERGENCY CONTACT PERSON		NEXT OF KIN CONTACT PERSON		
RELATIONSHIP	PHONE NUMBER	RELATIONSHIP	PHONE NUMBER	
ADDRESS		ADDRESS		

HEALTH INSURANCE INFORMATION

DO YOU HAVE MEDICARE COVERAGE?	YES	NO	DO YOU HAVE RAILROAD RETIREMENT COVERAGE?	YES	NO
DO YOU HAVE AHCCCS (MEDICAID)?	YES	NO	DO YOU HAVE PRIVATE INSURANCE COVERAGE?	YES	NO

MILITARY SERVICE?	YES	NO	BRANCH	CLAIM NUMBER	ENTRY DATE	SEPARATION DATE

VIETNAM VETERAN?	YES	NO	SERVICE CONNECTED?	YES	NO

HOUSEHOLD INFORMATION: How many family members in your household – including children?

PLEASE READ AND SIGN CAREFULLY

I authorize Winslow Indian Health Care Center to release any medical information or records necessary to process my Medicare, Medicaid or other insurance claims. I authorize my insurance company to pay medical benefits directly to Winslow Indian Health Care Center. If I am a non-beneficiary, I understand co-payments and deductibles will be requested at the time of service. I understand that I will be responsible for all costs if my account should be turned over to collections.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN	DATE

REVISED: 01/09/19

Phone: (928) 289-4646

Fax: (928) 289-9063

Patient Medical History- Mobile Dental Clinic

WIHCC | WINSLOW INDIAN HEALTH CARE CENTER

Name: (Last,First,Middle) Please Print*	Date of Birth:	School Name:

Have you been a patient in the hospital within the last two years? If YES, please write specifics of visit / admittance:

Please list any medications and or substances / drugs that you are now taking, or have taken in the last year. Please be specific:

PLEASE ANSWER EACH QUESTION WITH SPECIFIC STATEMENT

YES	NO	Are you allergic to any medications? Please list items:	
YES	NO	Chest pain or heart attack	Date of Attack:
YES	NO	Heart Murmur	Date of Diagnosis:
YES	NO	Heart Valve Replacement Surgery or Heart Surgery	Date of Surgery:
YES	NO	Rheumatic Fever	
YES	NO	Pacemaker	
YES	NO	High Blood Pressure	Have you taken your medication(s) today?
YES	NO	Stroke	
YES	NO	Epilepsy or Seizures	
YES	NO	Do you, or a relative have Diabetes?	Have you taken your medication(s) today?
YES	NO	Arthritis or Rheumatism	
YES	NO	Artificial Joint / Dentures	Which joint / Denture?
YES	NO	Asthma	
YES	NO	Tuberculosis	
YES	NO	Sinus Trouble	
YES	NO	Ulcers	
YES	NO	Kidney Disease or Dialysis	
YES	NO	Cancer or Tumors	
YES	NO	Hepatitis or Liver Disease	
YES	NO	Blood Transfusions	
YES	NO	Sexually Transmitted Disease	
YES	NO	Have you ever had any severe or uncontrolled bleeding?	
YES	NO	Have you been exposed to the AIDS Virus?	
YES	NO	Are you HIV positive?	
YES	NO	Do you use Alcohol?	
YES	NO	Do you use tobacco?	
YES	NO	Do you have any concerns about receiving Dental treatment?	

FEMALES ONLY

YES	NO	Are you Pregnant?
YES	NO	Are you on Birth Control?

Date of last Menstrual Period:

Comments:

Please list any other medical conditions that you may have:

The Photo Release is for the use of Winslow Indian Health Care Center or for any other publication(s) or purposes uses by the WIHCC now or anytime in the future. WIHCC may also use and/or publish my name in conjunction with this/these photograph(s), or use my name in an accompanying article related to the photograph, or any article(s) for WIHCC publications.

I further attest I am the parent or legal guardian and give Permission. Accept (_ _) Decline (_ _)

WIHCC DENTAL CONSENT FORM

Preventative Restoration is hard plastic coatings which protect the grooved surfaces of permanent teeth. They seal the deep pits and fissures and prevent decay. Minor risks include gagging, swallowing/aspiration of required dental materials, and small temporary change in bite.
Standard Restorations are amalgam or tooth colored fillings that are placed after all decay (caries) is removed.
Fluoride Varnish Program can help reduce cavities.
Periodontal Programs teach your child about gum disease and its prevention. Additionally, we may be able to provide a cleaning for certain grades as time and resources permit. Minor after effects may include bleeding or sore gums.
Emergency dental services are available as needed. If emergency treatment is necessary informal consent will also be obtained from the child's legal guardian (parent, school, representative, etc.)

Anesthetic Risks Include: discomfort, rapid pulse, swelling, bruising, infection, anxious feelings, allergic reactions, and lip chewing in children. Anesthetics occasionally are not effective in some patients.

We participate in School Externship/Residencies; Dental Students & Hygiene Students may see you.

The above answers are true to the best of my knowledge. I give my consent for myself or my child under the age of 18 to receive routine care such as examinations, x-rays, cleaning or fillings and for any other type of dental care as explained by the dentist.	
Signature or Thumbprint, Parent or Legal Guardian:	Date:
Signature of Dentist:	Date:

Phone: 928-289-6116

500 North Indiana Avenue, Winslow, AZ 86047

Facsimile: 928-289-6291

Dilcon Community School, Inc.

HC 63, Box G, Winslow, Arizona 86047 - Phone: (928) 657-3211 - Fax: (928) 657-3213

Health History Form
SY2021-2022

Student's Name:_____ Date of Birth:_____

Parent/Guardian's Name:_____ Date:_____

Has the student been in the hospital this past year?_____

_____

_____

Is the student taking any medications?_____

If yes, what is the name of the medication?_____

What is the medication for?_____

Does the student have allergies to anything?_____ What?_____

_____

Which hospital/clinic does the student usually go to?_____

_____

In case of an emergency who do we need to contact?_____

Who does the student live with?_____

What are the directions to the home where the child lives?_____

_____

Do you have any health concerns?_____

_____

Did your child receive any immunizations over the summer?_____

If yes, please list the date and where the immunization was given._____

_____

_____

Dilcon Community School, Inc.

HC 63, Box G Winslow, Arizona 86047 – Phone (928) 657-3211 – Fax: (928) 657-3213

William Wachunas, Principal

Rose Van Cruz, President
Terrance Yazzie, Vice-President
Wyatt Begaye, Secretary
Andrea Long, Member
Margie Barton, Member

Student Name:_____ **Grade:** **PreSchool/KG/1st/2nd/3rd/4th/5th/6th/7th/8th**

Permission to Administer OTC Medications at School

Dilcon Community School has common "over the counter" OTC, medications in our Health Techinician's office. We use brand names and generic name medicines. If you would like DCS to offer your child these medicines, please ***CIRCLE*** **"YES"** or **"NO"** for the following OTC medications listed below

YES	*NO*	**Aloe Vera Gel** – (Burns)
YES	*NO*	**Advil/Ibuprofen** – (Injury, pain and swelling)
YES	*NO*	**Bacitracin Zinc Ointment/Neosporin -** (Anti-infection ointment)
YES	*NO*	**Lip Balm/Carmex** – (Dry/chapped lips)
YES	*NO*	**Clear Eyes/Visine** – (Dryness, burning irritation of the eyes. Medication will ONLY be administered to students after consulting with parents.)
YES	*NO*	**Benadryl/Diphenhydramine** – (Oral medication given for suspected allergic reactions and seasonal allergic reactions and seasonal allergy symptoms, may cause drowsiness. Medication will ONLY be administered to students after consulting with parents. ***Cream/Ointment*** is used for itchy insect bites or rash.)
YES	*NO*	**Tylenol/Acetaminophen** – (Fever, Pain)
YES	*NO*	**Claritin/Loratidine** – (Oral medication given for suspected allergic reactions and seasonal allergy symptoms, does not induce sleep. Medication will ONLY be administered to students after consulting with parents.)
YES	*NO*	**Cortisone Cream/Anti-itch Cream** – (Insect bites, itching and inflammation of skin)
YES	*NO*	**Menthol Cough Drops** – (Cough)
YES	*NO*	**Pepto Bismol/Bismuth Subsalicylate** – (Diarrhea, nausea and upset stomach)
YES	*NO*	**Tums/Calcium Carbonate** – (Stomachache, heartburn)

I have circled "Yes" for medicines my child may be given at school and have circled "No" for medicines that should NOT be given to my child.

Parent/Guardian Signature:_____ Date:_____

For OFFICIAL USE ONLY

Received by Health Technician/Staff On:___/___/___ ***Signature:***_____

SY2021-2022

OMB Control No. 1810-0021 (Exp. 01/31/2024)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School Dilcon Community School, Inc. School District Tribal Grant School

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name Navajo Office of Vital Records & Identification Address PO Box 3240

City Window Rock State AZ Zip Code 86515

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____

State of Arizona
Department of Education
Office of English Language Acquisition Services

Primary Home Language Other Than English (PHLOTE) Home Language Survey

(Effective April 4, 2011)

These questions are in compliance with Arizona Administrative Code, R7-2-306(B)(1), (2)(a-c).

Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

1. **What is the primary language used in the home regardless of the language spoken by the student?** _____
2. **What is the language most often spoken by the student?** _____
3. **What is the language that the student first acquired?** _____

Student Name _____ Student ID _____

Date of Birth _____ SAIS ID _____

Parent/Guardian Signature _____ Date _____

District or Charter Tuba City

School Dilcon Community School

Please provide a copy of the Home Language Survey to the ELL Coordinator/Main Contact on site.

In SAIS, please indicate the student's home or primary language.

McKinney-Vento Student Residency Questionnaire
Dilcon Community School, Inc.

Student's Legal Name:_____

This questionnaire is intended to address the McKinney-Vento Homeless Act. Your answers will help the administrator determine residency documents necessary for enrollment of said student.

1. **Presently, where is the student living? (Check one box in Section A or Section B)**

SECTION A

The student lacks a fixed, regular and adequate nighttime residence and:

□ Shares housing of other persons due to loss of housing, economic hardship, or a similar reason (*doubled-up with more than one family*)

□ Lives in a motel, hotel, trailer park, camping grounds or similar setting

□ Lives in an emergency or transitional shelter

□ Lives with friends or family members (other than parent or guardian)

□ Lives in car, hotel/motel, substandard housing (lacking running water or electricity or adequate heat) and abandoned buildings

CONTINUE: **If you checked any box in SECTION A, complete #2 and the remainder of this form.**

SECTION B

□ Choices in Section A *Do Not Apply*
STOP: If you checked this section, you do not need to complete the remainder of this form.

2. **The student lives with:** □ 1 parent □ 2 parents □ 1 parent & another adult □ a relative, non-guardian or another adult

Student Date of Birth:_____ Age:_____ □ Female □Male

Name of Parent(s) or Legal Guardian(s):_____

Mailing Address:_____

Physical Address:_____

Home #:_____ Cell #:_____ Work #:_____

Parent/Legal Guardian Signature:_____ Date:_____

For any choices in Section A, this form must be completed and forward to the school liaison immediately. Form will be kept separately from the Student Permanent Record for Audit purposes during the school year.

SCHOOL OFFICIAL USE ONLY: Date forwarded to McK-Administrator:_____

SY2021-2022