SPECIAL SCHOLARSHIP
Jean Charley-Call Health Careers Scholarship Application

In partnership with the Call Family, we are pleased to announce the Jean Charley-Call Health Careers Scholarship. The scholarship was established by her family to honor Mrs. Jean Charley-Call. There are three $2,200.00 scholarships available for 3 full-time Hopi students pursuing a Health Career degree at an accredited college or university during Spring 2020.

In addition to general eligibility requirements, students must submit a Special Scholarship Application and a 1-page essay that answers the following: What is your inspiration for choosing the Health field? What are your plans upon completion of your program? Applications will be competitively reviewed based on the criteria listed below. Final recipients will be chosen by a Selection Committee. If you have any questions please contact the HTGSP.

ELIGIBILITY REQUIREMENTS

1. Jean Charley-Call Health Careers Scholarship Application (Special Scholarship Application)
2. Essay (1 page single spaced 12 point font) – Essay topic “What is your inspiration for choosing the Health field?” and “What are your plans upon completion of your program?”
3. Must be an enrolled member of the Hopi Tribe.
4. Be a high school graduate or have earned a GED certificate.
5. Be admitted to a regionally accredited college/university.
6. Must be pursuing a degree (Associates, Baccalaureate, Graduate) in a Health Career. Pre-Health Career majors are not eligible.
7. Under Graduate students must
   • Possess a Cumulative Grade Point Average (CGPA) of 2.50 at current institution attending.
   • Must be a full-time student at their institution
8. Graduate students must
   • Possess a Cumulative Grade Point Average (CGPA) of 3.0 at current institution attending
   • Must be a full time student at their institution

REQUIRED DOCUMENTS

1. Official high school transcripts or Official GED scores (Needs to be submitted only once)
2. Official transcript from community college/university currently attending.
3. Program of Study (POS)
4. Verification of Enrollment Form

These documents must be mailed from the institution to the HTGSP. ALL Transcripts must bear the official seal and be submitted in a sealed envelope. If you are a current HTGSP recipient you may already have some of the documents on file. Contact HTGSP to verify.

DEADLINE DATE
January 31, 2020

ALL DOCUMENTS MUST BE RECEIVED BY 5:00 P.M. (MST) ON OR BY THE DEADLINE DATE IN ORDER FOR APPLICATION TO BE REVIEWED. Faxed or photocopied documents shall not be accepted with the exception of the Financial Needs Analysis (FNA).
Grants and Scholarships Program
P.O. Box 123
Kykotsmovi, AZ 86039
800-762-9630 Toll Free Line
(928) 734-3542 Direct Line
Rpolivema@hopi.nsn.us

12.16.19 HEEF
# Jean Charley-Call Health Careers Scholarship Application

Grants and Scholarship Program  
P.O. Box 123  
Kykotsmovi, Arizona 86039  
(928) 734-3533 or (800) 762-9630  

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**Deadline Date:**  
January 31, 2020

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**ANSWER ALL QUESTIONS AND PRINT CLEARLY. READ, SIGN AND DATE THE APPLICATION.**

**Financial Assistance:**  
Terms applying for:

<table>
<thead>
<tr>
<th>(XX) Jean Charley-Call Health Careers Scholarship</th>
<th>Fall</th>
<th>Not available</th>
<th>(XX) full-time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spring</td>
<td>2020</td>
<td>(XX) full-time</td>
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**Name:** Last________________________ First________________________ Hopi Enrollment No.: __________________

**Social Security No.:**________________________  
**Date of Birth:**________________________  
**Sex:** ( ) Male ( ) Female

**E-mail address:**________________________  
**Mailing Address:**________________________  
**City:**________________________  
**State:**________________________ **Zip Code:**_________ **Phone:**(______)

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**Have you previously applied to HTGSP?** ( ) Yes ( ) No  
**If yes, semester/year applied:**________________________

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**High School attended/location:**________________________  
**Year Diploma/GED recd.:**________________________

**College to be attended/location:**________________________

**College Class Status (soph., junior, senior or graduate):**________________________  
**Expected date of college graduation:**________________________

**Degree currently pursuing (AAS, AA, BA, BS.):**________________________

**Major:**________________________  
**Minor:**________________________

**Please list all community colleges or universities attended (use additional page if necessary).**

<table>
<thead>
<tr>
<th>School</th>
<th>City/State</th>
<th>Sem./Yr. attended</th>
<th>Credits earned</th>
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</tr>
</tbody>
</table>

**Total Credit Hours Earned:**________________________
CONDITIONS FOR RECIPIENT:

A. The recipient is responsible for submitting to the HTGSP a new application for each academic year to be considered for the Jean Charley-Call Health Career Scholarship.

B. At the end of the Fall semester, all recipients must submit an grade report by January 15. At the end of the Spring semester all recipients must submit an official transcript by June 15.

C. Keep the HTGSP informed of student status, i.e. change of mailing address, name change, phone number, intention to withdraw or transfer etc.

D. Recipients must complete each term at a minimum as follows:

   Undergraduate- 12 credit hours with a minimum semester Grade Point Average (GPA) of 2.5.
   Graduate – 9 credit hours or full time equivalent with a minimum semester Grade Point Average (GPA) of 3.0

E. Recipients shall maintain a Cumulative Grade Point Average (CGPA) as follows
   Undergraduate- 2.50
   Graduate – 3.0

F. Recipients failing to maintain the appropriate CGPA and/or course load will be subject to termination and not eligible to re-apply.

G. The recipient shall attend the institution specified in the award letter.

H. The recipient shall be responsible for meeting other conditions as required by the Jean Charley-Call Health Career Scholarship.

I. The recipient agrees to have their name, school, degree being pursued, and graduation announcement released in any press releases by the HTGSP and HEEF.

J. The applicant’s file is the property of the HTGSP. In order that the HTGSP disclose information regarding the applicant’s status or award, the applicant must submit a signed Release of Information form specifying the individuals to receive information.

I hereby certify that the information on this application is true and correct to the best of my knowledge. I will accept and abide by all conditions in the aforementioned. Furthermore, I give permission to the HTGSP to request and receive any information on my financial aid status and academic progress.

Signature of Applicant: ___________________________ Date: ___________________________
Verification of Hopi Indian Blood for
Hopi Tribe Grants and Scholarships Program

PART I: MEMBERSHIP INFORMATION (To be completed by student and returned to HTGSP)

Student Name: ____________________________ Other Last Name(s) Used:________________________
Place of Birth: ____________________________ Date of Birth: ____________________________
Student Social Security No:__________________ Father’s Name: ____________________________
Mother’s Name: ____________________________ Mother’s Maiden Name:____________________

(To be completed by the Hopi Tribal Enrollment Office)

PART II: VERIFICATION OF TRIBAL BLOOD ENROLLMENT

A. Is ________________ blood degree of the Hopi Indian Tribe

B. a. __________________ Hopi Tribal enrollment number ____________________________
   b. ____________________ is not enrolled with the Hopi Indian Tribe.
      Is also ________ blood degree of the __________________ Tribe/Race
      Is also ________ blood degree of the __________________ Tribe/Race

We can verify that he/she is not enrolled with the ______________ Tribe(s) as of __________________(Date)

We are unable to verify non-enrollment with ____________________________ Tribe(s) due to lack of information.

PART III: CERTIFICATION OF INDIAN BLOOD

A. I certify that this individual is __________________________ degree Indian Blood of a federally recognized tribe defined in 25 CFR Part 40.1.

__________________________ Director, Office of Enrollment/Hopi Tribe ____________________________ Date

B. I am unable to certify the blood quantum or enrollment status of this individual due to no records on file with the Enrollment Office/Hopi Tribe.

__________________________ Director, Office of Enrollment/Hopi Tribe ____________________________ Date

PRIVACY ACT and REDUCTION ACT STATEMENT

GENERAL: This information is provided pursuant to P.L. 93-579 (Privacy Act of 12/21/74)

AUTHORITY: The Bureau of Indian Affairs, Office of Indian Education Programs operates an educational system under the general authority of Chapter 115, Public Law 67-86, 42 Stat. 208(25U.S.C. 13) and Public Law 95-561.

PURPOSE AND USES: In accordance with the accountability required for the administration of funds appropriated for educational program, certain types of information is required. All records are maintained in strictest confidence and all information contained herein is considered privileged information solicited and the routine use of the information collected will be used solely in the planning, managing, providing placement of individuals and providing accountability for the educational services offered to individuals.

EFFECTS OF NONDISCLOSURE: Although furnishing personal information to this office is purely voluntary, failure to supply complete and accurate information may preclude beneficiaries from obtaining the educational services.