

**NORDMEIER/TAFOYA MEMORIAL  
SCHOLARSHIP APPLICATION  
2018-2019**

PRINT OR TYPE

**I. PERSONAL DATA**

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Last 4 Digits of your Social Security No.: \_\_\_\_\_

Name of Montana Institute you will be attending: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Number of credits you anticipate enrolling for the 2018-2019 school year (**Students must enroll for at least 12 semester credits each semester for this scholarship**): \_\_\_\_\_

Anticipated grade level for 2018-2019:

Freshman (never attended college)

Sophomore

Senior

Freshman (previously attended college)

Junior

Graduate/Professional

Your Major: \_\_\_\_\_ Current Cumulative GPA: \_\_\_\_\_

**You must include a copy of your most recent transcript.**

Personal References:

| Name | Address | Phone |
|------|---------|-------|
|      |         |       |
|      |         |       |

**II. EDUCATION:**

Name of last high school attended, include city & state: \_\_\_\_\_

Names of other educational institutes attended, include city/state: \_\_\_\_\_

Date of Graduation/GED: \_\_\_\_\_

Honors & Awards Received: \_\_\_\_\_

Committees/Activities: \_\_\_\_\_

Personal Achievements: \_\_\_\_\_

**STATEMENT BY APPLICANT:** Narrative of the challenges you have overcome and how this scholarship will help meet your personal and educational goals. (No more than 1 typed page)

**IV. EMPLOYMENT HISTORY (last 5 years)**

1.

| Name & Address of Employer            | Dates of Employment |                   | Gross Monthly Earnings | Average hours worked per week? |
|---------------------------------------|---------------------|-------------------|------------------------|--------------------------------|
|                                       | From:               | To:               |                        |                                |
|                                       |                     |                   | \$                     |                                |
| Name & Telephone Number of Supervisor |                     | Title of Position |                        | Reason for leaving?            |
|                                       |                     |                   |                        |                                |
| Description of work:                  |                     |                   |                        |                                |
|                                       |                     |                   |                        |                                |

2.

| Name & Address of Employer            | Dates of Employment |                   | Gross Monthly Earnings | Average hours worked per week? |
|---------------------------------------|---------------------|-------------------|------------------------|--------------------------------|
|                                       | From:               | To:               |                        |                                |
|                                       |                     |                   | \$                     |                                |
| Name & Telephone Number of Supervisor |                     | Title of Position |                        | Reason for leaving?            |
|                                       |                     |                   |                        |                                |
| Description of work:                  |                     |                   |                        |                                |
|                                       |                     |                   |                        |                                |

3.

| Name & Address of Employer            | Dates of Employment |                   | Gross Monthly Earnings | Average hours worked per week? |
|---------------------------------------|---------------------|-------------------|------------------------|--------------------------------|
|                                       | From:               | To:               |                        |                                |
|                                       |                     |                   | \$                     |                                |
| Name & Telephone Number of Supervisor |                     | Title of Position |                        | Reason for leaving?            |
|                                       |                     |                   |                        |                                |
| Description of work:                  |                     |                   |                        |                                |
|                                       |                     |                   |                        |                                |

4.

| Name & Address of Employer            | Dates of Employment |                   | Gross Monthly Earnings | Average hours worked per week? |
|---------------------------------------|---------------------|-------------------|------------------------|--------------------------------|
|                                       | From:               | To:               |                        |                                |
|                                       |                     |                   | \$                     |                                |
| Name & Telephone Number of Supervisor |                     | Title of Position |                        | Reason for leaving?            |
|                                       |                     |                   |                        |                                |
| Description of work:                  |                     |                   |                        |                                |
|                                       |                     |                   |                        |                                |

**COMPLETE THE ATTACHED SELF-IDENTIFICATION OF HANDICAP**

STATEMENT BY APPLICANT: Narrative of the challenges you have overcome and how this scholarship will help meet your personal and educational goals. (No more than 1 typed page)

**V. FINANCIAL ELIGIBILITY STATEMENT** (Please read the Privacy Act Statement and the Information on the reverse side concerning inclusions and exclusions in family income before completing this section of the form. You may be asked to verify the information you provide.)

| INSTRUCTIONS: List yourself and all family members living in your household (include people related by blood, marriage, or adoption) and provide the following information: |              |                    |                              |
|---|--------------|--------------------|------------------------------|
| NAME  | RELATIONSHIP | 2017 ANNUAL INCOME | 2018 PROJECTED ANNUAL INCOME |
|   |              |                    |                              |
|   |              |                    |                              |
|   |              |                    |                              |
|   |              |                    |                              |
|   |              |                    |                              |
|   |              |                    |                              |
|   |              |                    |                              |
|   |              |                    |                              |
| Total Number:   |              | Total Amount:      | Total Amount:                |

If there is a substantial difference in 2017 Annual Income and 2018 projected income, please explain:

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Were you claimed as a dependent for income tax purposes on another individual's most recent return?  
 NO  YES  If "YES," on whose return?

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**VI. CERTIFICATION:**

I certify that all of the statements made by me are true, complete and correct to the best of my knowledge and belief, and are made in good faith.

Applicant's Signature and Date Signed

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**PRIVACY ACT STATEMENT**

Your Social Security Number (SSN) is required to keep your records straight because other people may have the same name and birth date. We may also use your SSN to make requests for information about you from employers, schools, banks, and others who know you, but only as allowed by the law or Presidential directive. The information we collect by using your SSN may be used for studies and statistics. Giving us your SSN or any of the other information is voluntary. However, we cannot process your application if you do not give us the information we request. Incomplete addresses and ZIP Codes will also slow processing.

**INCLUSIONS IN FAMILY INCOME**

Family income refers to total annual cash receipts before taxes from all sources. (Income data for a part-year period may be annualized.) These receipts include:

- Gross Wages and Salary - The total money earnings received from work performed as an employee. It represents the amount paid **BEFORE** deductions for income taxes, social security, bond purchases, etc.
- Net Self-Employment Income - Net income (gross receipts minus operating expenses) from a business firm, farm, or their enterprise in which a person is engaged on his/her own.
- Other Money Income - Money received from sources, such as public assistance payments (including Supplemental Security Income), social security or railroad retirement, unemployment and worker's compensation, strike benefits from union funds, training stipends, alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private and Government employees pensions, and regular insurance or annuity payments; and income from dividends, interest, rents, royalties, or periodic receipts from estates or trusts, and Veterans' benefits (i.e., education assistance, compensation payments).

**EXCLUSIONS FROM FAMILY INCOME**

The following should not be included in the computation of total family income:

- Capital gains.
- Any assets drawn down as withdrawals from bank, sale of property, house, or car.
- Tax refunds, gifts, lump-sum inheritances, one-time insurance payment or compensation for injury.
- Non-cash benefits such as employer-paid health insurance and other employee fringe benefits, food or rent received in lieu of wages, the value of food and fuel produced and consumed on farms, and the imputed value of rent from owner-occupied non-farm or farm housing.

**INDIVIDUALS CLAIMING SELF SUFFICIENCY**

If you are financially independent and (1) have not resided with your family for more than 6 months consecutively during the past 12-month period and (2) were not claimed as a dependent on another person's Federal income tax return for the last calendar year, you may be considered your own household of one person. If, however, you have resided on another person's Federal income tax return for the last calendar year, you may be considered your own household of one person. If, however, you have resided with your family for **more** than 6 consecutive months during the past 12-month period, the income of these family members must be reported on this form. The information presented on this application is subject to verification by the selection committee.

Submit application by April 5, 2018 to Western Area Power, Attn: Robin Johnson, Box 35800, Billings, MT 59107

**SELF-IDENTIFICATION OF DISABILITY**

(See Privacy Act information and additional instructions on reverse)

|                               |                       |                        |
|-------------------------------|-----------------------|------------------------|
| Last Name, First Name, and MI | Date of Birth (MM/YY) | Social Security Number |
|-------------------------------|-----------------------|------------------------|

**Purpose:**

Each agency in the Executive Branch of the Federal government has established programs to facilitate the hiring, placement, and advancement of individuals with disabilities. Self-identification of disability status is essential for effective data collection and analysis of the Federal government's efforts. While self-identification is voluntary, your cooperation in providing accurate information is critical to these efforts. Every precaution is taken to ensure that the information provided by each employee is kept in the strictest confidence.

**ENTER CODE HERE** →

| <b>Targeted Disabilities or Serious Health Conditions:</b>   | <b>Other Disabilities or Serious Health Conditions:</b>   |
|--|---|
| 02- Developmental Disability, for example, autism spectrum disorder<br>03- Traumatic Brain Injury<br>19- Deaf or serious difficulty hearing, benefiting from, for example, American Sign Language, CART, hearing aids, a cochlear implant and/or other supports<br>20- Blind or serious difficulty seeing even when wearing glasses<br>31- Missing extremities (arm, leg, hand and/or foot)<br>40- Significant mobility impairment, benefiting from the utilization of a wheelchair, scooter, walker, leg brace(s) and/or other supports<br>60- Partial or complete paralysis (any cause)<br>82- Epilepsy or other seizure disorders<br>90- Intellectual disability<br>91- Significant Psychiatric Disorder, for example, bipolar disorder, schizophrenia, PTSD, or major depression<br>92- Dwarfism<br>93- Significant disfigurement, for example, disfigurements caused by burns, wounds, accidents, or congenital disorders | 13- Speech impairment<br>41- Spinal abnormalities, for example, spina bifida or scoliosis<br>44- Non-paralytic orthopedic impairments, for example, chronic pain, stiffness, weakness in bones or joints, some loss of ability to use part or parts of the body<br>51- HIV Positive/AIDS<br>52- Morbid obesity<br>59- Nervous system disorder for example, migraine headaches, Parkinson's disease, or multiple sclerosis<br>80- Cardiovascular or heart disease<br>81 - Depression, anxiety disorder, or other psychiatric disorder<br>83- Blood diseases, for example, sickle cell anemia, hemophilia<br>84- Diabetes<br>85- Orthopedic impairments or osteo-arthritis<br>86- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema<br>87- Kidney dysfunction<br>88- Cancer (Present or past history)<br>94- Learning disability or attention deficit/hyperactivity disorder (ADD/ADHD)<br>95- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome, colitis, celiac disease, dysphexia |
| <p><b>Other Options:</b></p> 01 - I do not wish to identify my disability or serious health condition.<br><br>05 - I do not have a disability or serious health condition.<br><br>06 - I have a disability or serious health condition, but it is not listed on this form.   | 96- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis<br>97- Liver disease, for example, hepatitis or cirrhosis<br>98- History of alcoholism or history of drug addiction (but not currently using illegal drugs)<br>99- Endocrine disorder, for example, thyroid dysfunction   |

**Definition**

An individual with a disability: A person who (1) has a physical or mental impairment which substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment. This definition is provided by the Rehabilitation Act of 1973, as amended (29 U.S.C. 701, et seq.).

**The Rehabilitation Act of 1973**

The Rehabilitation Act of 1973, as amended (29 U.S.C. 701, et seq.), requires each agency in the Executive Branch of the Federal government to establish programs that will facilitate the hiring, placement, and advancement of individuals with disabilities. One method for determining agency progress in fulfilling these requirements is through the production of reports at certain intervals showing, for example, the number of employees with disabilities who are hired, promoted, trained, or reassigned over a given time period; the percentage of employees with disabilities in the work force and in various grades and occupations; etc. Such reports bring to the attention of agency top management, OPM, and the Congress, the progress or any deficiencies within specific agencies or the Federal government as a whole in the hiring, placement, and advancement of individuals with disabilities.

The disability data collected on employees will be used only in the production of reports such as those previously mentioned and not for any purpose that will affect them individually. The only exception to this rule is that the records may be used for selective placement purposes and selecting special populations for mailing of voluntary personnel research surveys. In addition, every precaution will be taken to ensure that the information provided by each employee is kept in the strictest confidence and is known only to those individuals in the agency Personnel Office, who obtain and record the information for entry into the agency's and OPM's personnel systems. You should also be aware that participation in the disability reporting system is entirely voluntary, with the exception of employees appointed under the Schedule A Excepted Appointing Authority for People with Intellectual Disability, Severe Physical Disability, or Psychiatric Disability (5 CFR 213.3102(u)). Agencies will request that these employees identify their disability status and, if they decline to do so, their correct disability code will be obtained from medical documentation used to support their appointment.

Employees who wish to confirm the disability code carried in their agency's and OPM's personnel systems is consistent with the employees' representation, may ask their Personnel Officer for a printout of the code and definition from their individual records. The code noted in the employees' records in the agencies' system will be identical to that carried in OPM's system.

**Privacy Act Statement**

Collection of the requested information is authorized by the Rehabilitation Act of 1973, as amended (29 U.S.C. 701, et seq.). Solicitation of your Social Security Number (SSN) is authorized by Executive Order 9397, which permits agencies to use the SSN as a means for identifying persons with disabilities in personnel information systems. Your SSN will only be used to ensure that your correct disability code is recorded along with other employee information that your agency and OPM maintain on you. It should be noted, however, that where individuals decline to furnish their SSN, the SSN will be obtained from other records in order to ensure accurate and complete data. Employees appointed under the Schedule A Appointing Authority for People with Intellectual Disability, Severe Physical Disability, or Psychiatric Disability (5 CFR 213.3102(u)) are requested to furnish an accurate disability code, but failure to do so will not affect them. Where employees hired under this authority fail to disclose their disability, the appropriate code will be determined from the employee's existing records or medical documentation submitted upon appointment.