



Oglala Sioux Tribe  
 Higher Education Grant Program  
 P.O. Box 562  
 Pine Ridge, SD 57770-0562  
 (605)867-5338 \* 1-800-832-3651 \* Fax: (605)867-1390  
 Email: [highered@gwtc.net](mailto:highered@gwtc.net)



**INSTRUCTIONS FOR ALL APPLICANTS**  
 (PLEASE FOLLOW ALL INSTRUCTIONS CAREFULLY TO ELIMINATE DELAYS)

- \*All awards are based on first come first serve; your file must be complete before review.
- \*Awards are contingent upon academic progress, financial need and availability of funds.

- \_\_\_\_\_ **APPLICATION FORM** – to be completed by the applicant.
- \_\_\_\_\_ **CERTIFICATE OF INDIAN BLOOD DEGREE** – showing that you are an “enrolled” member of the Oglala Sioux Tribe or a federally recognized Tribe.
- \_\_\_\_\_ **FINANCIAL AID NEEDS ANALYSIS FORM – Part 1** – applicant will complete the top portion of this form. **Part 2** - must be completed by your institutions financial aid office then returned to the OST Higher Education office. This form is the 3<sup>rd</sup> page of this packet.
- \_\_\_\_\_ **OFFICIAL COLLEGE TRANSCRIPT(S)** – for continuing and former students that have **received** an OST Higher Education Grant award.

**FOLLOW UP ON ALL OF YOUR PAPERWORK** – it is your responsibility to ensure all necessary documents are submitted by the deadline date to complete your file.

**Notify the Higher Education office of any changes, i.e., prior to transferring to another college.**

**\*\*\*\*\*DEADLINE DATES\*\*\*\*\***

**JUNE 15<sup>th</sup>** – ACADEMIC YEAR (includes Fall & Winter Quarters; Fall Trimester)

**NOVEMBER 15<sup>th</sup>** – SPRING TERM ONLY (includes Spring Quarter; Spring Trimester)

**APRIL 1<sup>st</sup>** – ALL SUMMER SESSIONS

**ALL FILES MUST BE COMPLETE BEFORE REVIEW**, applicants must also meet all other eligibility criteria.



# O.S.T. Higher Education Grant Application

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## \*\*\* APPLICANT INFORMATION \*\*\*

Please complete entire application

### APPLICATION FOR:

Academic Year 20\_\_\_\_ to 20\_\_\_\_  
(August - May)

Fall Only 20\_\_\_\_

Spring Only 20\_\_\_\_

\_\_\_\_\_  
Last Name                      First Name                      MI                      Maiden                      SSN

\_\_\_\_\_  
Mailing Address                      City                      State/Zip                      Telephone                      E-mail Address

\_\_\_\_\_  
Home Address                      City                      State/Zip                      Telephone

High School or GED Graduation Date & Where: \_\_\_\_\_

Have you ever applied for a Higher Education Grant:   If yes, when: \_\_\_\_\_

College/University attending: \_\_\_\_\_      \_\_\_ 2 Yr. College      \_\_\_ 4 Yr. College

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

City/State/Zip: \_\_\_\_\_      Telephone: \_\_\_\_\_

Academic Level:      \_\_\_ 1-32 Hrs.      \_\_\_ 33-64 Hrs.      \_\_\_ 65-97 Hrs.      \_\_\_ 98+ Hrs.      \_\_\_ Graduate  
(Year in College)      Freshman      Sophomore      Junior      Senior      Studies

College Major: \_\_\_\_\_      Expected Graduation Date: \_\_\_\_\_

Type of Degree you plan to receive:      \_\_\_ Associate Degree      \_\_\_ Bachelor Degree      \_\_\_ Graduate Degree

### **Statement of Certification and Consent for RELEASE OF INFORMATION**

I hereby certify that the above information on this form is true and correct to the best of my knowledge and consent to the release of this information to necessary agencies to complete my file. I understand that any grant awarded to me will be in care of the financial aid office at the college/university.

I will ensure that my Official College Transcript(s) are submitted from the College Registrar's Office by the established deadline date, to the O.S.T. Higher Education Grant Program at the end of each term I receive a grant award. I declare that I will use any funds I receive under the OST Higher Education Grant Program solely for expenses connected with attendance at this college/university.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date



# FINANCIAL AID NEEDS ANALYSIS FORM

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## \*PART 1 - APPLICANT INFORMATION \*

For:  Academic Year 20\_\_\_\_ to 20\_\_\_\_  
(August – May)  Fall Only 20\_\_\_\_  Spring Only 20\_\_\_\_

\_\_\_\_\_  
Last Name First Name MI Maiden SSN

\_\_\_\_\_  
Mailing Address City State/Zip Telephone E-mail

\_\_\_\_\_  
Home Address City State/Zip Telephone

## Statement of Certification and Consent for RELEASE OF INFORMATION

I hereby certify that the above information on this form is true and correct to the best of my knowledge and consent to the release of this information to necessary agencies to complete my financial aid package.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## PART 2 - TO BE COMPLETED BY THE FINANCIAL AID ADMINISTRATOR

College/University: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Community College

2 Yr. Institution

4 Yr. Institution

### PLEASE INDICATE SEMESTER OR QUARTER TERMS AND THE BUDGET PERIOD:

Budget Period from \_\_\_\_\_ 20\_\_\_\_ to \_\_\_\_\_ 20\_\_\_\_  Academic Year (Semester Terms)

Fall only (Semester Term)

Spring only (Semester Term)

Quarter Terms \_\_\_ Fall \_\_\_ Winter \_\_\_ Spring

#### Attendance Cost Budget:

Tuition \$ \_\_\_\_\_  
All Fees \$ \_\_\_\_\_  
Books/Supplies \$ \_\_\_\_\_  
Room/Board \$ \_\_\_\_\_  
Transportation \$ \_\_\_\_\_  
Personal Care \$ \_\_\_\_\_  
Child Care \$ \_\_\_\_\_  
Misc. Expense \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_

#### Resources & Other Aid:

Parent Contribution \$ \_\_\_\_\_  
Student Contribution \$ \_\_\_\_\_  
Tuition Waiver \$ \_\_\_\_\_  
Veteran Assistance \$ \_\_\_\_\_  
Voc. Rehab. \$ \_\_\_\_\_  
Student Incentive Grant \$ \_\_\_\_\_  
College/University Scholarship \$ \_\_\_\_\_  
Direct Tribal Assist. \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_

#### Federal Aid:

F.W.S. \$ \_\_\_\_\_  
PELL Grant \$ \_\_\_\_\_  
Perkins \$ \_\_\_\_\_  
Plus Loan \$ \_\_\_\_\_  
F.S.E.O.G. \$ \_\_\_\_\_  
Stafford Loan \$ \_\_\_\_\_  
Stafford UnSub. \$ \_\_\_\_\_  
College/University Loan \$ \_\_\_\_\_  
S.L.S. \$ \_\_\_\_\_

Total Cost: \$ \_\_\_\_\_

Total Resources & Aid: \$ \_\_\_\_\_

Total Federal Aid: \$ \_\_\_\_\_

The applicant's unmet need shall be determined by subtracting the total resources and total federal aid from the cost of attendance.

1) This applicant has a financial aid need at this institution: \_\_\_\_\_ Yes \_\_\_\_\_ No

2) Recommendation for OST Grant Award amount: \$ \_\_\_\_\_

Ineligible for PELL due to: \_\_\_\_\_

\_\_\_\_\_  
Signature of Financial Aid Administrator

\_\_\_\_\_  
Date