

KENTUCKY YOUTH CHALLENGE

Rev. 06/11/2026

STUDENT APPLICATION

Thank you for your interest in Kentucky Youth Challenge Our classes begin every January and July. This is a chance of a LIFETIME!!



We accept applications on a first come first served basis we urge you to get your application submitted as soon as possible. The classes fill up very quickly please do not wait until the last minute.



Bluegrass ChalleNGe Academy
114 Conroy Ave. Bldg. 5549
Fort Knox, KY 40121
1-877-599-6884
<http://www.bcachallenge.com>
jackie.donahue@bcachallenge.com

Eligibility requirements for our program:

- 16, 17, or 18 years of age upon entry (**have to be 16 years old by graduation date**)
- A youth who is failing in school, no longer attending school **and** who has not received a high school diploma or GED
- No felony convictions
- Resident of Kentucky (**non-state residents require prior approval**)
- Mentally and physically capable to participate in the program
- Volunteer to attend program
- Be free of illegal drugs (Candidates will be tested for drug use)
- Unemployed or underemployed

Directions and packing list will be forwarded after acceptance has been established to the program.

Application Instructions-Read Carefully

If you have questions about filling out the application, please contact the Academy. We recommend that you keep a copy of your entire application.

NOTE – Application should not be signed until in the presence of an admissions coordinator
Notary will be completed at your interview.

By typing my name in the boxes below I am offering my digital signature in lieu of my handwritten signature. I understand that my digital signature carries the same legal bindings as my handwritten signature. Int. ____

APPLICATION CHECKLIST
Incomplete applications will not be accepted!

3. Mentor Pledge Initial: _____
4. Eminence Schools Statement Initial: _____
- 5-6. Applicant & Parent/Legal Guardian information sheet Initial: _____
- 7-8. Report of Medical History (Include documentation or explain questions 10 & 11) Initial: _____
9. Report of Medical History (Part 2) Initial: _____
10. Insurance Information Initial: _____
11. Legal Information (Law Violations) Initial: _____
12. Special Power of Attorney for the Authorization of Medical Care and Medical Expense Statement Initial: _____
13. Certificate of Understanding and Release of Liability Initial: _____
14. Acknowledgment of Legal Custody & Drug, Alcohol, Pregnancy and HIV Testing Initial: _____
15. Release of Information Form Initial: _____
16. Workers Comp, Privacy Act, Unauthorized Absence & Acknowledgment of App. Initial: _____
- 18-20. Kentucky Youth Challenge WellFront Counseling Survey & Primary Care Physician Information Initial: _____
- Copy of Official Birth Certificate (do not send original)
Copy of Social Security Card (do not send original)
Copy of Immunizations/ Shot records (do not send original) Initial: _____
- Copy of Front and back of Medical Insurance Card(s) Initial: _____
- Tetanus needs to be up to date
(Meningococcal) booster dose (Age: 16 years) and Hep A must be current
- Copy of High School Disenrollment Form
- Copy of High School Transcript Must be on hand not later than Day 15

Dental work, eye exams, and medication needs should be taken care of before coming to Kentucky Youth Challenge.

- * Prescription Medication will not be accepted if it is older than 30 days
- * Do not send vitamins or over the counter medicine
- * If applicant takes medication, he/she must come with a 30 day supply



The following agreement acknowledges that the Cadet and parent/guardian will need to stay in touch with the Bluegrass Challenge Academy Case Management team for a duration of 24 months after graduating from the program for the Mentoring part of the program.

Purpose:

The purpose of this Agreement is to establish a mutual commitment between the Cadet and the Case Manager to maintain regular contact for a period of **24 months** following the Cadet’s successful graduation from the Bluegrass Challenge Academy. This continued engagement intends to support the Cadet’s transition, stability, and progress in their personal and professional development and to inform families of the new Post-Residential Contact and Placement BCA manages.

The Parent/Guardians and the Cadet understand and agree to:

- Remain in contact with the assigned Case Manager for a period of 24 months after graduation.
- Provide updates every month post-graduation about current goal status.
- Inform the Case Manager of any major life events, such as employment, housing, education changes, or challenges that may arise.

PLEDGE AGREEMENT (Parent/Guardian & Cadet) Between the Case Manager and Cadet

This Pledge Agreement is made and entered into by and between:

Cadet: _____

Cadet Cell Phone: _____

Cadet E-mail: _____

Parent/Guardian Signature: _____

Recruiter Witness Signature: _____

Parent/Guardian Cell Phone: _____

Parent/Guardian E-mail: _____

Vision

All children are worth fighting for, and Bluegrass ChalleNGe Academy (BCA) is an environment where a partnership between the Kentucky National Guard and Eminence Independent will foster the highest educational environment for the students attending.

Educational Endeavor

Students enrolled in BCA receive educational services through Eminence Independent, a public school. Due to the nature of the program, online courses are the vehicle for educational instruction. Currently, EDGENUITY is the learning platform which is used and courses are assigned to the student that will help them gain credit during their time in the classroom.

Educational Rights

The BCA Acceptance Board handles admission into BCA. Once a cadet is accepted to the program and meet the qualifications of BCA, the student is then eligible to have their educational needs met through Eminence Independent Schools. The students in attendance are attending a public school. Procedural safeguards and the law as pertaining to IDEA and ESSA are consistent at Bluegrass ChalleNGe Academy.

Timelines

When students enter the National Guard Youth ChalleNGe Program, there is a 2 week "Acclimation Period" where cadets are readying their minds and bodies for the demands of behavior modifications that many will find beneficial. Students attending this program, have often had truancy or behavioral infractions at their schools previously attended. This highly structured program, builds character and helps to foster skill sets and tools that will help them to succeed in the real world. After the acclimation period ends, students are ready to begin their educational journey. At this point, classes begin and they become members of Eminence Independent School System for approximately 95 days.

ARC Meetings and IEP Documents

Admissions Mentoring Placement Coordinators (AMP's) are the liaisons between families and BCA. It is important to let the AMP's know if your student has an active IEP and they currently receive services from the school district previously attended. These documents can be given to the AMP's to facilitate identification so once enrolled in Eminence Independent School, they can have the continuum of services met. If the student is from out of state, an ARC meeting will be held and an IEP developed. The previous IEP can be consulted by the special education staff to provide guidance on the services needed to best suit each child. Often, IEP's might have to be modified to specify the special education setting, the least restrictive environment, modifications, and special education services.

I have read and understand the above information:

Parent or Guardian Signature

Date of Signature

APPLICANT INFORMATION SHEET

Applicant's Information: Print Clearly and fill in ALL of the information

Today's Date: _____ Social Security# _____

Have you applied here before Yes No If Yes, when: _____

Last Name _____ First Name _____ MI _____

Date of Birth: _____ Age: _____ Gender: Male Female

Last Public School Attended _____

Last Day of Attendance _____ Highest Grade Completed _____

Do they have an IEP? Yes No

Are you employed? Yes No If Yes, Occupation _____

Ethnicity (Must Check One) American Indian/Alaskan Native Asian/Pacific Islander

Black Hispanic White Religion: _____

Married Yes No Number of Children _____

Are you currently free from illegal drugs and/or alcohol: Yes No

Applicant's Contact Information

Home Phone _____ Email _____

Address _____

City _____ County _____ State _____

Zip _____

I certify that _____ (applicant) is not a high school graduate, does not have an alternative certificate or GED nor is currently attending school _____ (initial) or the last day of attendance will be _____ (date) _____ (initial).

PARENT/LEGAL GUARDIAN INFORMATION SHEET

Parent/Guardian Information

A.

Relationship to Applicant: _____

Last Name _____ First Name _____ MI _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Address _____

City _____ County _____ State (Abr.) _____

Zip _____

Is this Person Authorized for pickup? Yes No

Legal Guardian? Yes No Emergency Contact? Yes No

B. **Relationship to Applicant:** _____

Last Name _____ First Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Address _____

City _____ County _____ State (Abr.) _____

Zip _____

Is this Person Authorized for pickup? Yes No

Legal Guardian? Yes No Emergency Contact? Yes No

REPORT OF MEDICAL HISTORY

Last Name _____ First Name _____ MI _____

ANSWER ALL QUESTIONS, PUT N/A IF NOT APPLICABLE FAILURE TO DISCLOSE KNOWN ISSUES COULD RESULT IN DENIAL OF ENROLLMENT OR TERMINATION IF IDENTIFIED AT A LATER TIME.

1. Statement of Health: Good Fair Poor

Explain _____

2. Current Medication(s)

Please give name of medication, dosage of medication, and time given. Use a new line for each medication.

3. In the past two years, has the applicant taken any type of medication that he/she no longer takes (DO NOT include over-the-counter medication & antibiotics that he/she is no longer taking)

Yes No

If Yes, list what type and why the applicant stopped taking the medication:

4. Allergies (INCLUDE INSECT BITES, COMMON FOODS, AND MEDICATIONS) _____

5. Ht. _____ Wt. _____ Eye Color _____ Hair color _____

6. Physician Name: _____ Phone: _____

7. Psychiatrist/Psychologist Name: _____ Phone: _____

8. Dentist Name: _____ Phone: _____ Last Exam: _____

9. Braces? Yes NO Orthodontist Name and Ph# _____

10. Have you ever been hospitalized for an illness or injury Yes No

If so; when, where, and why?

*11. Have you ever consulted or been treated by a psychiatrist, psychologist, therapist, and/or counselor? Yes No

If yes, please choose one: Comp Care Private Practice Other

Name/Phone Number: _____

Reason: _____

*12. Have you been hospitalized in the last 12 months for any illness, injury, and/or mental disorder? Yes No If yes: Date: _____

Reason: _____

**13. Have you had a broken bone in the last 6 months? Yes No

If yes: Date: _____

If so, describe what happened: _____

14. Glasses? Yes No Optometrist Name and Ph# _____

15. Has the child ever had suicidal ideations or been hospitalized? Yes No

16. Has the child ever attempted suicide? Yes No

When did this occur? _____

Did the child receive treatment? Yes No

Date of completed treatment/release from doctor: _____

***Note: If you answered "YES" questions 12 and 13, and it has been in the last 12 months, all records must be sent with your application**

****If you answered yes to question 16 you must provide a doctor's release with your application**

REPORT OF MEDICAL HISTORY

Last Name: _____ First Name _____

MI _____ CHECK ALL OF THE ITEMS THAT APPLY NOW OR THAT YOU HAVE EVER EXPERIENCED. SELECT CURRENT IF THE CONDITION IS WITHIN THE LAST 12 MONTHS. SELECT PAST IF THE CONDITION OCCURRED OUTSIDE OF 12 MONTHS. P = PAST/C= CURRENT

| P / C | P / C | P / C | P / C | | |
|---|---------------------------|---|-----------------------------|---|----------------------------------|
| <input type="checkbox"/> <input type="checkbox"/> | Thyroid trouble/goiter | <input type="checkbox"/> <input type="checkbox"/> | Eye/ear/nose/throat trouble | <input type="checkbox"/> <input type="checkbox"/> | Adverse reaction to medication |
| <input type="checkbox"/> <input type="checkbox"/> | Bone/joint deformity | <input type="checkbox"/> <input type="checkbox"/> | Frequent indigestion | <input type="checkbox"/> <input type="checkbox"/> | Chronic/frequent colds or coughs |
| <input type="checkbox"/> <input type="checkbox"/> | Skin disorders | <input type="checkbox"/> <input type="checkbox"/> | Pregnant at this time | <input type="checkbox"/> <input type="checkbox"/> | Depression or heavy weeping |
| <input type="checkbox"/> <input type="checkbox"/> | Sinusitis/hay fever | <input type="checkbox"/> <input type="checkbox"/> | Paralysis | <input type="checkbox"/> <input type="checkbox"/> | "Trick" knee/shoulder/elbow |
| <input type="checkbox"/> <input type="checkbox"/> | Tumor/growth/cyst/cancer | <input type="checkbox"/> <input type="checkbox"/> | Nose bleeds | <input type="checkbox"/> <input type="checkbox"/> | Obsessive Compulsive Disorder |
| <input type="checkbox"/> <input type="checkbox"/> | Lameness or neuritis | <input type="checkbox"/> <input type="checkbox"/> | Behavior Disorder | <input type="checkbox"/> <input type="checkbox"/> | Oppositional Defiant Disorder |
| <input type="checkbox"/> <input type="checkbox"/> | Nervous disorder | <input type="checkbox"/> <input type="checkbox"/> | Stomach/intestinal | <input type="checkbox"/> <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> <input type="checkbox"/> | Bi-Polar | <input type="checkbox"/> <input type="checkbox"/> | Epilepsy/seizures/fits | <input type="checkbox"/> <input type="checkbox"/> | Asthma/shortness of breath |
| <input type="checkbox"/> <input type="checkbox"/> | Broken bones | <input type="checkbox"/> <input type="checkbox"/> | Gall bladder trouble | <input type="checkbox"/> <input type="checkbox"/> | Treated for female disorders |
| <input type="checkbox"/> <input type="checkbox"/> | Rupture/hernia | <input type="checkbox"/> <input type="checkbox"/> | Jaundice/hepatitis | <input type="checkbox"/> <input type="checkbox"/> | Severe tooth or gum trouble |
| <input type="checkbox"/> <input type="checkbox"/> | Rectal disorder | <input type="checkbox"/> <input type="checkbox"/> | Motion Sickness | <input type="checkbox"/> <input type="checkbox"/> | Change in menstrual cycle |
| <input type="checkbox"/> <input type="checkbox"/> | ADD/ADHD | <input type="checkbox"/> <input type="checkbox"/> | Bleeds easily | <input type="checkbox"/> <input type="checkbox"/> | Painful/frequent urination |
| <input type="checkbox"/> <input type="checkbox"/> | Coughed up blood | <input type="checkbox"/> <input type="checkbox"/> | Arthritis/rheumatism | <input type="checkbox"/> <input type="checkbox"/> | Dizziness/fainting spell |
| <input type="checkbox"/> <input type="checkbox"/> | Anemia/Sickle Cell | <input type="checkbox"/> <input type="checkbox"/> | Recent gain/loss of weight | <input type="checkbox"/> <input type="checkbox"/> | Palpitation/pounding heart |
| <input type="checkbox"/> <input type="checkbox"/> | Attempted suicide | <input type="checkbox"/> <input type="checkbox"/> | Liver disorder/disease | <input type="checkbox"/> <input type="checkbox"/> | Kidney stone/blood in urine |
| <input type="checkbox"/> <input type="checkbox"/> | Leg/feet cramps | <input type="checkbox"/> <input type="checkbox"/> | Frequent trouble sleeping | <input type="checkbox"/> <input type="checkbox"/> | Frequent/severe headaches |
| <input type="checkbox"/> <input type="checkbox"/> | Recurrent back pain | <input type="checkbox"/> <input type="checkbox"/> | Diabetes/hypoglycemia | <input type="checkbox"/> <input type="checkbox"/> | Loss of finger/toe/arm/leg |
| <input type="checkbox"/> <input type="checkbox"/> | Knee brace/back support | <input type="checkbox"/> <input type="checkbox"/> | Had 1 or more children | <input type="checkbox"/> <input type="checkbox"/> | Sugar/albumin in urine |
| <input type="checkbox"/> <input type="checkbox"/> | Head injury | <input type="checkbox"/> <input type="checkbox"/> | Eating Disorder | <input type="checkbox"/> <input type="checkbox"/> | Heart trouble/murmur |
| <input type="checkbox"/> <input type="checkbox"/> | Swollen or painful joints | <input type="checkbox"/> <input type="checkbox"/> | Unconsciousness | <input type="checkbox"/> <input type="checkbox"/> | High/low blood pressure |
| <input type="checkbox"/> <input type="checkbox"/> | Bedwetting since age 12 | <input type="checkbox"/> <input type="checkbox"/> | Sleepwalker | <input type="checkbox"/> <input type="checkbox"/> | Speech Impairment |
| <input type="checkbox"/> <input type="checkbox"/> | Scarlet/Rheumatic fever | <input type="checkbox"/> <input type="checkbox"/> | Loss of Memory/Amnesia | <input type="checkbox"/> <input type="checkbox"/> | Hearing Impairment |
| <input type="checkbox"/> <input type="checkbox"/> | Tuberculosis | | | | |

INSURANCE INFORMATION

Insurance Information: Include copy of front and back of insurance card.

Medical

Name of Insurance Company: _____

Is This Medicaid/State Insurance? YES: NO:

Subscriber's Name: _____

Subscriber's Birthday: _____

Subscriber's Place of Work: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Identification Number: _____

Group Number: _____

Pharmacy

FSA Card

HRA Card

Pharmacy Card

Card # _____ ID # _____ RX Group # _____

PCN # _____ RX Bin # _____ Pharmacist Call # _____

Dental

Dental Insurance Company Name: _____

Dental Insurance Phone: _____

Dental Insurance ID: _____

Vision

Vision Insurance Company Name: _____

Vision Insurance Phone: _____

Vision Insurance ID: _____

LEGAL INFORMATION

Last Name: _____ First Name: _____ MI _____

1. Have you ever been arrested and/or charged with a crime? Yes No
If you answered "No", go to the next page

2. If you answered "Yes" to question #1, please complete the following:

Date: _____

Place of Offense: City _____ County _____ State _____

Offense/Violation: _____ Misdemeanor Felony

Name & Location of court: _____

Penalty Imposed/Disposition _____

CDW: Name _____ Phone _____

Date: _____

Place of Offense: City _____ County _____ State _____

Offense/Violation: _____ Misdemeanor Felony

Name & Location of court: _____

Penalty Imposed/Disposition _____

CDW: Name _____ Phone _____

Date: _____

Place of Offense: City _____ County _____ State _____

Offense/Violation: _____ Misdemeanor Felony

Name & Location of court: _____

Penalty Imposed/Disposition _____

CDW: Name _____ Phone _____

3. Are you Currently awaiting a hearing or sentencing? Yes No

4. If you are awaiting a hearing or sentencing, what is the scheduled date/time and city/county?

Date _____ Time _____ City _____ County _____

**SPECIAL POWER OF ATTORNEY AUTHORIZING MEDICAL CARE
& EXPENSES (TO BE NOTARIZED)**

Appointment of Attorney-in-Fact for Obtaining Health Care

That I _____ as parent/legal guardian of, _____ Guardian (or Applicant if 18 years of age)
Applicant's Printed First and Last Name)

A Cadet of the Kentucky Youth Challenge Academy, appoint the Kentucky Youth Challenge Academy, and its authorized agents, as my attorney-in-fact for purposes of obtaining health care; medical treatment; and /or psychological treatment for the benefit of the cadet.

Authorization for Treatment by Youth Challenge Academy Medical Staff – Specifically, I acknowledge the medical staff at Kentucky Youth Challenge Academy consists of a Registered Nurse, a Licensed Practical Nurse and a contracted Medical Director. Determinations regarding appointments, administering treatments, medications, approved diagnosis and all other actions approved by the Medical Director will be carried out by the nursing staff in accordance with the laws of the State of Kentucky.

Authorization for Treatment by Medical Care Providers – Further, I specifically authorize Kentucky Youth Challenge Academy to act in loco parentis for the cadet to obtain the medical care and medical treatment deemed advisable or necessary to benefit and/or maintain the health of the cadet. I intend for the Kentucky Youth Challenge Academy to perform any and all acts as fully to all intents and purposes as I might or could if were personally present: to authorize and provide for the care, maintenance, well-being and health including, but not limited to, authorizing any and all medical and hospital care and treatment, regardless of whether on an emergency basis, including major surgery deemed necessary by a duly licensed staff physician at any hospital whether within or without the territorial limits of the State of Kentucky.

Authorization for Distribution of Medication by Youth Challenge Academy Cadre – Further, I specifically authorize Kentucky Youth Challenge Academy Cadre, under the instruction and supervision of Kentucky Youth Challenge Academy medical staff, to distribute over-the-counter and prescription medications to the cadet in accordance with those times and dosages set forth by the prescribing practitioner and/or the medical staff of the Kentucky Youth Challenge Academy.

Intent to Hold Harmless – It is my intent that the Kentucky Youth Challenge Academy and its lawful agents, cadre, the medical facility and any doctors, nurses and other medical personnel involved in providing care or advice shall have no civil or criminal liability for honoring my wishes as expressed in this designation or for implementing the decisions of my attorney-in-fact.

Medical Expense Statement of Understanding- I acknowledge the Kentucky Youth Challenge Academy **DOES NOT** pay for medical expenses incurred by the cadet if the injuries/illnesses are caused by cadet participating in a non-sanctioned Youth Challenge Academy activity and I acknowledge and agree I, as the parent/legal guardian, regardless of insurance coverage, am responsible for all medical and psychological expenses, to include all co-payments, deductibles, and all non-covered expenses. The Academy will provide physician; hospital or pharmacy needs with the appropriate insurance information or Medicaid/Medical coverage.

Durable Power of Attorney – Date of Expiration

I intend for this Appointment of Attorney-in-Fact for Obtaining Health Care to be a Durable Power of Attorney and to remain in effect if I become disabled, incapacitated or incompetent. **This Appointment of Attorney-in-Fact shall remain in effect from the _____ day of _____ 20 _____ Until the cadet graduates from the Academy or is released from the Academy.**

Applicant Signature

Applicant Printed Name

Date

Parent/Legal Guardian Signature

Parent/Legal Guardian Printed Name

Date

State of Kentucky, County of _____

Before me, a Notary Public in and for the State of Kentucky, personally appeared the above person(s) personally known to me and proved to me on the basis of satisfactory evidence, to be the person(s) whose name(s) is/are subscribed to this document and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity. IN WITNESS THEREOF, I have affixed my signature hereto this _____ day of _____, 20 _____.

Signature of Notary Public

Printed Name of Notary

A resident of _____

Please Place Stamp/Seal here:

My Commission Expires: _____

CERTIFICATE OF UNDERSTANDING AND RELEASE OF LIABILITY

*If the applicant is 18 years of age he/she should enter their own name on the first line and enter "N/A" on the second line.

I, _____ applicant/parent or guardian of,
_____ with the Challenge Academy, hereby certify:

1. That I permit my child to participate in all Academy activities which may include UNIQUE activities such as rappelling, ropes course, Red Cross blood donations, aircraft rides (to include military aircraft), extreme physical activities, and various off campus activities; to include transportation to and from such events and travel in and outside of Kentucky in various types of vehicles. This release also includes all activities that might be involved with the Mentor assigned by the Academy to the student. This release shall remain in effect for the 17 ½ month duration of both Residential and post-Residential program.

2. The Academy has my permission that upon arrival for intake or after any outing off-campus, my child and their personal belongings will be searched for contraband. Random searches may also be warranted in conjunction with Fort Knox Military Police and any trained staff due to being a drug-free facility on a federal military installation.

3. That the Academy has my permission to release photographs of my child to the media and non- confidential information of my child to the same for publicity purposes.

4. That the Academy has permission for my child to participate in the GED, SAT, ACT, ASVAB, TABE or any other academics related to test.

5. That I give my permission for my child to receive counseling services from the Kentucky Youth Challenge personnel. Services may include mental health and/or substance abuse counseling, and psychological/educational tests.

6. If my child becomes a danger to himself/herself, I hereby give my permission for the personnel to take necessary measures to maintain his/her safety which may include a referral for psychological evaluation and/or hospitalization.

7. That the Academy's policies and procedures have been explained to me and I understand what the Academy will attempt to do.

8. That I give my permission for the Academy Staff to maintain discipline by imposing disciplinary measures upon my child.

9. I Understand that as a Credit Recovery participant, should my child resign or be terminated no credit earned will be awarded.

Furthermore, in consideration of my child's participation in the Academy, I HEREBY RELEASE the State of Kentucky, the officers, agents, employees, successors and assigns from any and all liability which may arise from my child's participation in the Academy. I AGREE to hold harmless the State of Kentucky National Guard, the National Guard Youth Challenge Program, the officers, agents, employees, successors and assigns regarding any liability or cause of action which may arise from my child's participation in the Academy.

*The applicant is 18 years of age and has signed this form personally.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF LEGAL CUSTODY
DRUG, ALCOHOL, PREGNANCY TEST ACKNOWLEDGEMENT

In the event that the undersigned is a Parent of the Applicant, rather than a Guardian, then it is hereby agreed that a copy of the Applicant's Birth certificate shall suffice as proof of same.

In the event that the undersigned is a Guardian rather than a Parent of the Applicant, then said Guardian hereby agrees to attach hereto any documentation (i.e., court order, probated will, etc.) necessary to prove guardianship of Applicant.

*If the applicant is 18 years of age he/she should enter their own name on the first line and enter "N/A" on the second line.

I, _____, applicant/parent/legal guardian of _____, hereby authorize my son/daughter to be tested by qualified individuals for drugs and alcohol at the end of Pre-Challenge.

I also understand that my daughter will be tested for pregnancy during the course of the intake physical and may be tested any time deemed necessary during the course of the program.

I also understand that during the course of the program my son/daughter may be randomly tested for drugs, alcohol, pregnancy.

I also understand that a positive test result for drugs or alcohol will subject my child to immediate expulsion from the program.

*The applicant is 18 years of age and has signed this form personally.

Signature: _____ Date: _

RELEASE OF INFORMATION LETTER

Last Name: _____ First Name: _____ MI: _____

Social Security # _____ DOB: _____

I consent for the release of the information requested below from the staff at the Challenge Academy.

Parent/Legal Guardian's Signature _____

Date _____

(This authorization shall remain effective from one year from date of signature)

ACADEMY USE ONLY

The LEGAL GUARDIAN hereby authorizes release of the following information records to
Kentucky Youth Challenge:

- Intake, psychological, psychiatric evaluations
- Medical History/Record
- Substance Abuse (alcohol/drug abuse)
- Psychological Testing
- Other
- Juvenile Court Records
- Penal Institution
- Treatment notes and summaries
- School records (IEP reports, etc.)

To: (Name/Title) _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

I consent to the release to provide essential background information to assess the needs of the cadet requiring assistance in counseling and to coordinate or facilitate social/community services.

CHALLENGE ACADEMY REPRESENTATIVE

DATE

CHALLENGE ACADEMY

WORKERS COMPENSATION STATUS

All Cadets are neither considered federal employees nor are they a member of the National Guard except under certain provisions of the law. They shall be considered federal employees for the purposes of compensation for work related injuries, or relating to the liability of legal conduct of employees of the United States. No Cadet will be considered to be in performance of duty while not at the assigned location of training or other activity authorized by the program agreement except while the Cadet is traveling or is on a pass or any other activity. All Cadets when receiving benefits for disability or death, the monthly pay that is received will be under the salary for a grade GS-2 federal employee. Further Cadets must understand the entitlement to receive compensation for disability will begin on the day following the date the person's participation terminates from the program.

PRIVACY ACT

"Personal Information is required and protected under the Privacy Act of 1974. Kentucky Youth Challenge operates as an entity of state government, organized under state law. Data for program operations is required and protected under Public Law 102-484, Section 1091 e (2). Disclosure is voluntary, however; persons failing to provide the information requested on this document will not be considered for participation in the program. Information provided on this application and generated during residential and post residential performance will only be used by the program to meet federal and state requirements and will not be released to any party outside the Youth Challenge organization, our inspectors/evaluators, or based upon requirements dictated by competent legal authority."

UNAUTHORIZED ABSENCE

"I understand that all Kentucky Youth Challenge participants are there as volunteers and regardless of the training location agree to follow the rules and guidelines of the program and the instructions of staff supervising their activities. I understand that every effort of the supervising staff is intended to insure cadets operate in a safe, secure and managed environment. I understand that if my child chooses to absent himself from planned activities, there is little the program can do to absolutely prevent this type of behavior. I also understand that immediately upon any action my child takes to absent themselves from program activity or supervision without proper authority; I absolve Kentucky Youth Challenge of any liability due to this action. I understand Kentucky Youth Challenge will take immediate steps to locate my child once the absence is identified, and will process a missing person's report with all local authorities and notify me at this point. I also understand that any participant who is absent without proper authority for more than 24- hours may be terminated from attendance.

ACKNOWLEDGEMENT OF APPLICATION

I have read and understand all pages of the application. I hereby agree that all information is true and complete to the best of my knowledge. I understand that if the application is not complete, the applicant will not be accepted. I also understand that if I willfully mislead or fail to disclose all necessary information it will cause denial of the application.

Applicant Signature _____

Notary ID number _____

Parent/Legal Guardian Signature _____

Notary Signature _____

Date _____

Date _____

BCA Applicant Interview Questions

1. How did you learn about Bluegrass ChalleNGe Academy?
2. Why have you selected to attend Bluegrass ChalleNGe?
3. What are you wanting to get out of attending BCA?
4. What obstacles would you like to overcome in life?
5. What are your Strengths/Weaknesses?
6. Where do you see yourself in 5 years?



Permission to Obtain/Release Confidential Information

Name of Client: _____

Date of Birth: ___/___/___

I hereby give consent to WellFront RS to exchange pertinent and relevant information with the **Bluegrass Challenge Academy**.

Name: Kentucky National Guard/Dept.of Military Affairs

Street: 114 Conroy Ave, Bldg 5549

City/State/Zip: Fort Knox, KY 40121 Phone: 877-599-6884 Fax: 502-624-1300

Information obtained may include (check all that apply):

- Clinical Impressions and Records
- Academic Records (cumulative records, report cards, standardized test scores, etc.)
- Health Records
- Special Education Records/504 Plan Records (IEP, 504 Plans, PPT/Student Study Team minutes, evaluations)
- Psychiatric Evaluations
- Psychological Evaluations
- Social Work Evaluations
- Educational Evaluations
- Speech and Language Evaluations
- Other Evaluations (vocational, occupational, etc.)
- Other _____

Client/Parent/Guardian Signature: _____

Print Name: _____

Relationship to Client: _____

Date: _____



CONSENT AND ACKNOWLEDGEMENT STATEMENT FOR BEHAVIORAL HEALTH SERVICES

CLIENT INFORMATION

Client Full Name: _____

Date of Birth: _____

CLIENTS RIGHTS AND RESPONSIBILITIES

As a WellFront client, you have the right to confidentiality of the information you share with your counselor within all Federal and State mandates.

WellFront views health care as a partnership between you and your healthcare team. We respect your rights, values, and dignity. You will receive safe, high-quality medical care regardless of your race, color, national origin, religion, gender, age, sexual orientation, gender identity or expression, genetic information, veteran status, or disability. In exchange, we ask that you recognize the responsibilities that come with being a patient, both for your own well-being, and that of your fellow patients and health care providers.

- You have the right to safe, high-quality, medical care, without discrimination, that is compassionate and respects your personal dignity, values, and beliefs.
- You have the right to participate in and make decisions about your care, including refusing care, to the extent permitted by law. Your care provider will explain the consequences of refusing recommended treatment.

FREEDOM OF CHOICE FOR SERVICES

As the parent/guardian, I understand that the choice of providers is my responsibility and right. I further understand that I have the right to contact the providers prior to selection so that I may determine the best provider for my child. I also understand that I may at any time choose another provider for this service by notifying my current provider.⁴

Services Rendered:

Case Management, Collateral Therapy, Individual Therapy, Group Therapy

I have elected to receive the above indicated services through WellFront BH.

CONSENT FOR TREATMENT

The undersigned agrees to participate in evaluation and treatment provided by WellFront and its staff. The undersigned understands that he/she may withdraw from treatment at any time.

AUTHORIZATION FOR DISCLOSURE

The undersigned authorizes WellFront to release all client information, including specific information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the client is being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS), to any insurance company, and/or third party payers, or representative providing coverage for WellFront, or to any representative including, but not limited to WellFront employees/subcontractors, other healthcare professionals or organizations.

The confidentiality of alcohol and drug abuse client records is protected by Federal law and regulations (HIPAA). Generally, WellFront may not disclose information to anyone outside of WellFront which would IDENTIFY any client as an alcohol or drug abuser unless the client has authorized in writing; the disclosure is allowed by a court order, or the disclosure is made to medical personnel in accordance with Federal regulations.

CONFIDENTIALITY LIMITS

The undersigned acknowledges that issues discussed in treatment are legally protected as "confidential" and "privileged." However, there are limits to this privilege:

1. Suspected abuse or neglect of a child, elderly person, or disabled person.
2. When there is a danger of the client harming themselves or others.
3. If the client reports intent to physically injure someone (Duty to Warn).
4. When ordered by a court of law.
5. Insurance company involvement (claims, audits, case reviews).
6. Natural disasters where records may become exposed.
7. When otherwise required by law.

GRIEVANCE PROCEDURE ACKNOWLEDGEMENT (UNDER 18)

I have had the Client Grievance process explained to me and understand that I/my child may file a grievance if rights have been violated. Staff is responsible for assisting in this process.

CLIENT FINANCIAL RESPONSIBILITY AND BILLING DISCLOSURE

- **Medicaid:** WellFront is an approved provider for Kentucky Medicaid. Certain services are exempt from co-payments under Kentucky Medicaid regulations.
- **Commercial Insurance:** As part of our contractual agreements with specific in-network commercial payers, we do not collect co-payments directly from clients for covered services. Reimbursement will be processed directly through the insurance carrier.

RECORD KEEPING & PRIVACY POLICY

The undersigned acknowledges a clinical record is maintained describing condition, treatment, and progress. Clinical charts are stored according to HIPAA. Clients are allowed one copy of their medical record free of charge. I acknowledge that I have been given a copy of the **Notice of Privacy Practices**.

PCP CONSENT AUTHORIZATION**PRIMARY CARE PHYSICIAN (PCP) INFORMATION**

PCP Name/Clinic: _____

PCP Phone Number: _____

Please check one:

I GIVE PERMISSION to contact the PCP listed above to share information about diagnosis and/or treatment (excluding HIV blood test results). This consent expires 180 days from signing.

I DO NOT GIVE PERMISSION to contact the PCP. I understand this does not affect my insurance coverage.

SIGNATURE AND ACKNOWLEDGEMENT

By signing below, I acknowledge understanding of the Consent and Acknowledgement Statement and have been provided a copy of the Privacy Notice. I release WellFront BH and its agents/employees from any liability connected with the activities to which this consent relates.

Guardian/Authorized Representative Name (Printed):

Guardian Signature: _____

Date Signed: _____