KENTUCKY YOUTH CHALLENGE

STUDENT APPLICATION

Rev. 09/24/2026

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. ___

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?

APPLICATION CHECKLIST
Incomplete applications will not be accepted!

2. Applicant Interview Questions Initial: _____

4. Monthly Cadet Report Post-Residential Pledge 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: _____

11-14. KY Youth Challenge SOP Candidate/Cadet Screenings Initial: _____

15. Cadet Search Acknowledgment Form Initial: _____

16. Legal Information (Law Violations) Initial: _____

17. Special Power of Attorney for the Authorization of Medical Care and Medical Expense Statement Initial: _____

1 8 . Certificate of Understanding and Release of Liability Initial: _____

19. Legal Acknowledgment / Juvenile Release Initial: _____

20. Acknowledgment of Legal Custody &Drug, Alcohol, Pregnancy and HIV Testing Initial: _____

21. Release of Information Form Initial: _____

22. Workers Comp, Privacy Act, Unauthorized Absence & Acknowledgment of App. Initial: _____

23-25. Kentucky Youth ChalleNGe WellFront Counseling Survey & Primary Care Physician Information Initial: _____

26. Eminence Schools Statement 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

(Meningacoccal) 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: _____

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

Kentucky Youth ChalleNGe
Standard Operating Procedures (SOP)
Candidate/Cadet Screenings

1. **Purpose:**
   This Standard Operating Procedure (SOP) outlines the steps and guidelines for conducting screenings of cadets and academy areas to detect and prevent the presence of contraband items within a military or educational institution. The primary aim is to maintain safety, discipline, and security within the organization.

2. **Scope:**
   This SOP applies to all Academy Personnel in regard to conducting screenings on cadets.

3. **Definitions:**
   a. Cadet: A student or trainee enrolled in a Youth Challenge Program.

   b. Contraband: Prohibited items or substances as defined by the organization's policies and local laws.

   c. Authorized Personnel: An individual with the authority to perform screenings in accordance with this SOP.

   d. Stick & Poke: A form of makeshift tattoo.

4. **Responsibilities:**
   a. All Academy personnel are responsible for conducting screenings in a professional, respectful, and non-discriminatory manner.

   b. Cadets are responsible for cooperating during the screening process, which includes following instructions and providing any necessary assistance.

   c. The facility will ensure that proper privacy safeguards are present.

   d. The facility will ensure proper PPE is provided to personnel.

5. **Search Procedure:**
   5.1. Notification and Authorization:
   a. Screenings should be conducted on Intake/admission to Academy and throughout the residential Phase as needed based on credible information, reasonable suspicion, or as part of routine security procedures.

b. Screenings will always be conducted with two or more trained staff members of the same sex as the cadet/candidate.

c. The authorized personnel must obtain proper authorization from the chain of command or relevant authority before initiating a screening.

5.2. Privacy and Respect:

a. Screenings must be conducted in a private area to protect the cadet's privacy. Necessary safeguards such as privacy screens or separate walls/partitions must be utilized.

b. Cadets will be treated respectfully throughout the screening process.

5.3. Informed Consent:

a. Authorized personnel should inform the cadet about the reason for the screen and request their voluntary cooperation.

b. Cadets may give or withhold consent. If consent is not given by the cadet, and ample evidence is available to indicate a need for an applicable search, the candidate/cadet may be terminated from the program, at the discretion of the Program Director.

5.4. Screening Methods:

a. Cadet's Person:

i. Begin by visually inspecting the cadet's clothing and belongings for any signs of contraband and conduct a metal detecting wand search.

ii. The search/screen should focus on outer clothing and should not involve any type of touching. At no time should staff touch the cadet, and no forms of "frisking" or "pat-down" style tactics be employed. Progressive searching may only occur for established routine practices, such as initial screenings or for-cause screenings. If removal of clothing is required, the utmost considerations will be given for respect and privacy and should only be implemented as necessary to satisfy security concerns. Candidates/cadets will only be directed to remove outer layer of clothing; at no time will cadets/candidates be requested to be present beyond a minimum of a Physical Training (PT) uniform. Searches must be private and will not require the cadet to pull clothing aside or disrobe in any manner.

iii. Program staff must use a metal detecting wand or equivalent to search cadets while wearing the PT uniform. Again, staff will not frisk nor touch the cadet during the search in manner. All staff that utilizes a wand style device, must have adequate training and guidelines for operation.

iv. Invasive or deliberate cavity searches are never permitted for any cause.

v. Authorized personnel will maintain a safe and respectful distance while conducting the search, using the least amount of encroachment necessary to achieve the safety results.

vi. All program staff will receive training on the approved search procedures SOP and relevant policies from both the program level and the NGYCP prior to supervising cadets. Training will also be conducted annually.

b. Personal Belongings:
i. Inspect bags, backpacks, or any personal items cadets have with them.

c. Area Screenings:
i. Begin area screenings using the least invasive scope possible. Start with the immediate area concerning the suspected location or belongings then broaden the scope of the screening as necessary. Inform chain of command of increase in screening parameters.

ii. Items moved or disturbed during screening should not be intentionally damaged and should be placed back in their original conditions where possible. Any accidental damage of items should be noted to chain of command.

d. Body Screenings:
i. Body screenings are conducted periodically or under suspicion for specific purposes such as self-harm, Stick & Poke tattoos, injuries stemming from physical altercations/abuse, and hazing/bullying. Body screenings are defined as a visual assessment only by Academy Medical Staff, Contract Physician, or Cadre Supervisor of the same sex of the cadet. If there is potential signs of self-harm or physical abuse/bodily harm that is readily visible during a search, the staff will note the issue and refer that candidate to the medical department for further evaluation by the licensed medical professional(s) on site.

ii. All prescribed methods will be followed for these types of screenings. Candidates/cadets will not be in less than the minimum PT uniform and must not require the cadet to pull clothing aside or disrobe.

iii. Documentation of state of findings will be placed in the cadet's file. Findings of self-harm/tattooing/ or other meaningful marks that may lend insight into previous habits or behavior will be noted on a body check list as well as a clean finding for record.

iv. These screenings should be conducted with the goal of identifying behavioral health safety concerns or biological concerns that accompany introduction of sharp objects into the body. Staff shall instruct the youth to verbally indicate the location of any scars, bruises, birthmarks, tattoos, or any other marks known. Conditions of the skin including trauma markings, bruises lesions, jaundice,

rashes and infestations, recent tattoos and needle marks, or other indications of drug use shall be documented. If additional screening is required to ensure cadet safety/security, cadet will be transported to Academy Physician for further screening. Health trained staff shall review the body identification section of the Initial Health screening in accordance with policy.

5.5. Handling Contraband:

a. If contraband is discovered, secure the contraband item(s) and maintain a chain of custody. Notify chain of command of findings.

5.6. Reporting:

a. Complete a detailed written report of the screening, including the reason for the screening, the individuals involved, the findings, and any actions taken.

b. Submit the report to the relevant authority or supervisor as per organization policy.

c. If illicit items are discovered, chain of command will follow applicable laws and established reporting procedures.

6. **Training:**
   a. All personnel must receive proper training in search procedures, privacy rights, and conflict resolution techniques.

   b. Training should be periodically reviewed and updated as needed.

7. **Compliance:**
   a. Any violation of this approved SOP constitutes as a Hands-Off Leadership policy violation and requires a Serious Incident Report and investigation which could result in disciplinary action.

COLDIRON.JOSHUA.M.1408832124 Digitally signed by COLDIRON.JOSHUA.M.1408832124 Date: 2026.09.10 10:06:36 -04'00'

Director, Appalachian ChalleNGe Academy

HAMPTON.TROY.W.1290071832 Digitally signed by HAMPTON.TROY.W.1290071832 Date: 2026.09.10 10:28:30 -04'00'

Director, Bluegrass ChalleNGe Academy

Bluegrass ChalleNGe Academy

www.bcachallenge.com

114 Conroy Avenue

Fort Knox, KY 40121

Phone (877) 599-6884

Fax (502) 624-1300

CADET SEARCH ACKNOWLEDGEMENT FORM

The Kentucky Youth ChalleNGe Program (KYYCP) is committed to maintaining a safe, respectful, and secure environment for all cadets. To ensure the safety and well-being of participants, we follow a Standard Operating Procedure (SOP) for cadet screenings to detect and prevent the presence of contraband and to address any potential behavioral or health-related concerns.

Summary of Search Procedures:

- Screenings may occur upon intake and throughout the residential phase based on routine checks, credible information, or reasonable suspicion.
- All screenings are conducted by trained staff of the same sex as the cadet in a respectful, professional, and non-invasive manner.
- Cadets are not touched or frisked during screenings. Only outer clothing may be removed if necessary, and privacy measures will always be in place.
- Body screenings (visual only) may be conducted to identify signs of self-harm, stick & poke tattoos, or physical injuries, and will be performed by designated medical or supervisory staff.
- Cadets may consent to or decline a screening. However, refusal without justification may result in dismissal from the program at the discretion of the Program Director.
- All findings, including contraband or behavioral health concerns, will be documented and reported in accordance with program policy.

KYYCP requests that Parents/Guardians review search procedures with their cadet and discuss the importance of their cooperation during these procedures.

Acknowledgment and Consent

I acknowledge that I have read and understand the Kentucky Youth ChalleNGe Program Cadet Screening procedures. I understand the procedures described above and give consent for my child to be screened in accordance with these guidelines. I understand that these measures are in place to ensure the safety, security, and well-being of all cadets and staff.

Cadet Full Name: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

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 Cadre – Further, I specifically authorize Kentucky Youth ChalleNGe Academy Cadre, under the instruction and supervision of Kentucky Youth ChalleNGe 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 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 anyother 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.

Parent/Guardian Signature: _____ Date: _____

Candidate/Cadet Signature: _____ Date: _____

Bluegrass ChalleNGe Academy

www.bcachallenge.com

114 Conroy Avenue

Fort Knox, KY 40121

Phone (877) 599-6884

Fax (502) 624-1300

LEGAL ACKOWLEDGEMENT / JUVENILE RELEASE

By signing below, you authorize Juvenile Justice to verify and release your adjudication history. For youth currently supervised, you are authorizing Juvenile Justice to verify and release information or court orders, probation or other conditions (terms of supervision) to the Youth Challenge program to determine your eligibility. Applicants must not be under indictment, or ever convicted of a felony (or any crime that would be considered to be a felony if perpetrated by and adult), and not currently on parole or probation for other than juvenile status offenses or misdemeanors.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Applicant Printed Name: _____

Applicant Signature: _____ Date: _____

Juvenile Probation Officer/Authorized Representative

Name: _____

Phone #: _____

Email: _____

If 18, has the applicant ever been charged or convicted of a felony offense? ☐ No ☐ Yes

----------Below to be completed by Juvenile Justice Representative ----------

I, _____, juvenile probation officer or authorized Juvenile Justice Representative, for Youth Challenge program applicant above, declare that he/she is not currently under indictment, or ever convicted of a felony (or any crime that would be considered to be a felony if perpetrated by an adult), and not currently on parole or probation for other than juvenile status offenses or misdemeanors. If currently supervised, he/she does not have unresolved charges or will not have court requirements for the 22 weeks they will be residing at the Youth Challenge Program, and I support their attendance.

_____ _____ _____

Juvenile Justice Staff Signature Title 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 in-take 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_____

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: _____

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