KENTUCKY YOUTH CHALLENGE
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!!

Applications are accepted on a first come first serve basis, with limited spots available.
Please do not wait until the last minute to apply!

Appalachian ChalleNGe Academy
465 Grays Drive, PO Box 539
Grays Knob, KY 40829
1-855-596-4927
Fax: 1-606-574-0362
www.ChalleNGeACA.com
admissions@challengeaca.com

www.facebook.com/acaharlan

@Challenge_ACA

Eligibility requirements for our program:

- 16, 17, or 18 years of age upon entry
- A youth who is struggling in school or no longer attending school and who has not received a high school diploma or a GED
- No pending felony charges or felony convictions
- Resident of Kentucky
- 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 a 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. Initials:______

Do Not Send a check or Money Order with the Central Registry Check.

Revised ? ay 2& 2021

APPLICATION CHECKLIST

Pg. #

Incomplete applications will not be accepted!

3-4. Applicant & Parent/Legal Guardian information sheet

5-7. Report of Medical History (Include documentation or explain questions 10 & 11)

8. Insurance Information

9. Legal Infromation (Law Violations)

10. Special Power of Attorney Authorizing Medical Care and Expenses.

11. Certificate of Understanding, Release of Liability, and Release of Information

12. Release of Information Letter

14-18 Mentor Application

Central Registry Background Form

Supporting Documents

Copy of Official Birth Certificate (do not send original)

Copy of Social Security Card (do not send original)

Copy of Front and back of Medical Insurance Card(s) (do not send original)

Copy of Immunization/Shot record (do not send original and tetanus needs to be up to date)

Copy of High School Withdrawal 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, THIS INCLUDES MEDICATION IN A BOTTLE. NO EXCEPTIONS!! Please do not send vitamins or any over the counter medication. If the applicant takes medication, he/she must come with a 30 day supply!

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_____________

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_____________________________

Please provide a copy of the applicants High School Transcript and Official Withdrawal Form after he/she is withdrawn from school.

I certify that______________________________ (applicant) is not a high school graduate, does not have an alternative certificate or GED, and is no longer 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**_____

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**_____________________ **MI**_______

Home Phone____________________________ **Work Phone**__________________________

Cell Phone__________________________ **Email**____________________________________

Address____

City___________________________ **County**_______________________ **State**_____

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 THE QUESTION DOES NOT PERTAIN TO YOU. FAILURE TO DISCLOSE KNOWN ISSUES COULD RESULT IN DENIAL OF ENROLLMENT

1. Statement of Health: Good Fair Poor

Explain____

2. Current Medication(s)

Name	Dose	Time(s) Given
__________________________________	____________	_________________________
__________________________________	____________	_________________________
__________________________________	____________	_________________________

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 & anti-biotics 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. Physcian Name:________________________________ Phone:_______________________

7. Psychiatrist/Psychologist Name:_________________________ Phone:_________________

8. Dentist Name: ____________________________ Phone:_____________ Last Exam: _________

REPORT OF MEDICAL HISTORY (CONT)

9. Braces? Yes No

Orthodontist Name____ Phone____________________

10. Glasses? Yes No

Optometrist Name____ Phone____________________

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

If so; when, where, and why? ____

____

*12. 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: ____

____

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

Reason:____

____

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

If yes: Date: ___________________

If so, Describe what happened: ____

____

*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 14 you must provide a doctors 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 MONTS. SELECT PAST IF THE CONDITION OCCURRED OUTSIDE OF 12 MONTHS. P = PAST/C= CURRENT

P / C

Thyroid trouble/goiter

Bone/joint deformity

Skin disorders

Sinusitis/hay fever

Tumor/growth/cyst/cancer

Lameness or neuritis

Nervous disorder

Bi-Polar

Broken bones

Rupture/hernia

Rectal disorder

ADD/ADHD

Coughed up blood

Anemia/Sickle Cell

Attempted suicide

Leg/feet cramps

Recurrent back pain

Knee brace/back support

Head injury

Swollen or painful joints

Bedwetting since age 12

Scarlet/Rheumatic fever

Tuberculosis

P / C

Eye/ear/nose/throat trouble

Frequent indigestion

Pregnant at this time

Paralysis

Nose bleeds

Behavior Disorder

Stomach/intestinal

Epilepsy/seizures/fits

Gall bladder trouble

Jaundice/hepatitis

Motion Sickness

Bleeds easily

Arthritis/rheumatism

Recent gain/loss of weight

Liver disorder/disease

Frequent trouble sleeping

Diabetes/hypoglycemia

Had 1 or more children

Eating Disorder

Unconsciousness

Sleepwalker

Loss of Memory/Amnesia

P / C

Adverse reaction to medication

Chronic/frequent colds or coughs

Depression or heavy weeping

“Trick” knee/shoulder/elbow

Obsessive Compulsive Disorder

Oppositional Defiant Disorder

Sexually Transmitted Disease

Asthma/shortness of breath

Treated for female disorders

Severe tooth or gum trouble

Change in menstrual cycle

Painful/frequent urination

Dizziness/fainting spell

Palpitation/pounding heart

Kidney stone/blood in urine

Frequent/severe headaches

Loss of finger/toe/arm/leg

Sugar/albumin in urine

Heart trouble/murmur

High/low blood pressure

Speech Impairment

Hearing Impairment

INSURANCE INFORMATION

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

Medical

Name of Insurance Company:____

Subscriber's Name:____

Subscriber's birthday:____________________ Social Security #

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____

Probation Officer: Name_______________________________________ Phone___________________________

Date:________________________

Place of Offense: City________________________ County______________________________ State____________

Offense/Violation:____ Misdemeanor Felony

Name & Location of court:____

Penalty Imposed/Disposition____

Probation Officer: Name_______________________________________ Phone___________________________

Date:________________________

Place of Offense: City________________________ County______________________________ State____________

Offense/Violation:____ Misdemeanor Felony

Name & Location of court:____

Penalty Imposed/Disposition____

Probation Officer: 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 (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 Frist and Last Name)

A Cadet of the Kentucky Youth Challenge Academy, appoint the Kentucky Youth Challenge Academy, and it's 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. In accordance with program requirements, I hereby authorize medical staff at Kentucky Youth ChalleNGe Academy to test my son/daughter for drugs, alcohol, STI, HIV, and pregnancy any time deemed necessary during the course of the program. I understand that a positive test result for drugs/alcohol will subject my child to immediate expulsion from the program.

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, to include but not limited to primary care, dental care, emergency care, and ophthalmology. 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. If my child becomes a danger to himself/herself, I hereby give my permission for necessary measures to be taken to maintain his/her safety which may include a referral for psychological evaluation and/or hospitalization.

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 it's 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 Medical or Medicaid 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 form 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 Signature**	**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**	**Commission Expiration**

A resident of ______________________________ Please Place Stamp/Seal here:

____

CERTIFICATE OF UNDERSTANDING, RELEASE OF LIABILITY, & RELEASE OF INFORMATION

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

Having applied for enrollment with the Kentucky Youth 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, aircraft rides (to include military aircraft), extreme physical activities, and various off campus activities; to include transport 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 the Residential and Post-Residential program.**
2. **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.**
3. **That the Academy has permission for my child to participate in the TABE, ASVAB, ACT, SAT, GED, or any other academic related tests.**
4. **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.**
5. **That I give my permission for the Academy staff to maintain discipline by imposing disciplinary measures upon my child.**
6. **That I give my consent for the release of the following information records to Kentucky Youth ChalleNGe: intake, psychological, and psychiatric evaluations or tests; medical history/record; substance abuse history/record; juvenile court records; penal institution; treatment notes and summaries; school records (transcripts, IEP records, etc.); other records deemed necessary for successful evaluation of the child's participation in the program.**

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.

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 persons participation terminates from the program.

PRIVACT 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 ensure 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 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, will notify me at this point, and will process a missing person's report with all local authorities. I also understand that any participant who is absent without proper authority for more than 24 hours may be terminated from attendance."

______________________________	______________________________	______________________________
Applicant Signature	**Applicant Printed Name**	**Date**
______________________________	______________________________	______________________________
Parent/Legal Guardian Signature	**Parent/Legal Guardian Printed 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

____ _____________

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""""KENTUCKY YOUTH CHALLENGE MENTOR APPLICATION

Appalachian ChalleNGe Academy
465 Grays Drive, PO Box 539
Grays Knob, KY 40829
1-855-596-4927
Fax: 1-606-574-0362
www.ChalleNGeACA.com
acamentors@challengeaca.com

Every cadet attending Kentucky Youth ChalleNGe **must** have a mentor. Choosing a mentor is a very important decision. Please put some thought into the process, the mentor should be someone that **you**, the applicant, select. Your parents or guardian may make suggestions, but the decision should be yours.

Mentor qualifications:

- Be at least 21 years old.
- Be of the same sex (exceptions may be permitted)
- Not live in the same household with the cadet.
- Should live in the same general area as the cadet.
- **Cannot** be a mother, father, sister, brother, or guardian.
- **May** be a grandparent, uncle, aunt, cousin or friend, school employee, minister, etc.
- Has **never** been convicted as a sex offender or facing pending charges.
- Does **not** have a felony record or pending charges.
- Is **not** alcohol or drug dependent.

A background check will be requested and paid for by the ChalleNGe Academy.

Duties of a Mentor (Short Overview):

- Attends a minimum 4-hour Mentor Training Class (at a regional location) to learn the **Keys to Mentoring Success.**
- Serves as a role model and friend to the cadet and helps the cadet to stay on track to obtain his/her goals after graduation.
- After graduation, makes regular contact with the cadet. Ideally, the goal is 4-contacts a month with one contact being personal (fact-to-face). Other contacts may be by any form of the social media. (Purpose of the contacts is so the mentor can keep up with the cadet's progress and lend encouragement and direction.)
- After the cadet graduates, prepares and submits a monthly report on the cadet's progress to the Case Workers. (Part of the 4-hour training will include the reporting process.) Due by the 10th of every month.
- The mentoring formally ends 12-months after the cadet graduates.

For more information or to answer your questions, contact us at 855-596-4927 or email acamentors@challengeaca.com.

- Page 2-Mentor Personal Information.
- Page 3-Mentor Authorization to Release Information.
- Page 4-Mentor Position Description.
- Page 5-Mentor Liability Release.

Revised: February 22, 2021

MENTOR APPLICATION

Cadet Last Name: __________________________ First Name: ______________________ Middle Initial: _____

Mentor's Last Name: ______________________ First Name: ____________________Middle: ___________

Mailing Address: ____

Home Address: ____

(If you receive your mail at a PO Box, put your street address here.)

City: ________________________ County: _________________ State: ______ Zip Code: ______________

Home Phone: (_____)___________________________ Work Phone: (_____)___________________________

Cell Phone: (_____)___________________ Drivers License #: _________________________

E-Mail: ______________________________________ **SS #________________ DOB ___/___/_____________

(**Social and Drivers License #'s are required to complete a criminal background check)

Gender: Male Female Marital Status:_____________ Aliases/Nick Names_____________________________

Relationship to Candidate _______________ Length of time lived in Kentucky _____________________________

Ethnicity: (must check one) American Indian/Alaskan Native Asian or Pacific Islander Black

Hispanic Multi-racial White

Name of Employer: ____

Occupation: ____

Work Address: ____

City: ________________________ County: _________________ State: ______ Zip Code: ______________

Work Schedule: ____ Example: 8:00a.m.- 4:30p.m. or swing shift,etc

Date Interviewed: Amps Initials:

Please list Two (2) references:

Name:____ Phone #:_________________

Date Verified ____________________________ Amps Initials _____________________

Name:____ Phone #:_________________

Date Verified ____________________________ Amps Initials ______________________

I DO NOT PRESENTLY HAVE ANY CASES PENDING AGAINST ME IN THE LEGAL SYSTEM; I AM IN GOOD HEALTH AND I AM NOT NOW NOR WILL I BE DRUG OR ALCOHOL DEPENDENT DURING MY MENTORSHIP.

____ ___________________________________

SIGNATURE OF MENTOR APPLICANT DATE

KENTUCKY YOUTH CHALLENGE
MENTOR AUTHORIZATION TO RELEASE INFORMATION

I, ____, hereby authorize the Kentucky Youth Challenge, along with the law enforcement departments, to conduct whatever background search that may be deemed appropriate.

The information and background search is necessary to assist in determining my qualifications and suitability for the Volunteer Mentor Position I am seeking with the Kentucky Youth Challenge.

I fully understand that the information collected may be of a sensitive, confidential, and privileged nature, and may reflect upon my suitability for this position. I hereby release Kentucky Youth Challenge and its agents from liability and damage that may result from the exchange of requested information between law enforcement departments and the Kentucky Youth Challenge

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.

____ ____________________

SIGNATURE OF MENTOR APPLICANT DATE

MENTOR POSITION DESCRIPTION

Position Summary:

- The mentor serves as a role model, friend, and adviser to the cadet for 12 months after the cadet graduates.
- The mentor works with only one cadet unless approved by the academy director.

Responsibilities:

- Attends a minimum 4-hour mentor training class (at a regional location) to learn the **Keys for Mentoring Success**
- Submits monthly mentor reports promptly to the case manager. Part of the 4-hour training session will include how to prepare and submit the report and why the reports are required.
- Makes regular contact with the cadet. Ideally, the goal is 4 contacts a month with one contact being personal (face-to-face). Other contacts may be by any form of social media. Purpose of the contacts is so the mentor can keep up with the cadet's progress and lend encouragement and direction if needed.
- If a face-to-face contact is not possible, uses any form of social media for all contacts.
- Works with the cadet to help him achieve the goals he has outlined for himself in the Post Residential Action Plan (PRAP).
- Informs the case manager if the cadet is not cooperating or otherwise having problems.
- Refers the cadet to community resources as needed and helps the cadet obtain those resources
- If possible, plans activities with the cadet that will be of interest to both the cadet and mentor. The activities need not be expensive.
- Treats information shared by the cadet confidentially.

All the above-listed items will be explained in more detail during the training sessions.

I have read the Position Description for a Mentor and agree to adhere to the requirements to the best of my ability as indicated by my signature below.

______________________	______________________________	__________
Print Name	Signature	Date

KENTUCKY YOUTH CHALLENGE
MENTOR LIABILITY RELEASE

I understand and agree that I will be the one actually spending time with my matched-cadet and that I must exercise care in supervising my cadet while we are together.

I also understand and agree that I am not a Challenge Program agent, and that I am responsible for choosing and conducting all activities with my cadet and the Challenge Program does not retain any power to control how these activities are conducted except to require these activities to be conducted in the State of Kentucky.

I therefore agree that the Challenge Program will not be liable for, and I agree to hold the Challenge Program harmless from any and all liability, causes of action and losses imposed on it in any way relating to or arising out of this mentoring agreement, including, but not limited to, liability for personal injuries, whether the liability, cause of action, or loss is caused by my negligence, the Challenge Program's negligence or otherwise.

I further release the Challenge Program from any and all liability, claims, demands or actions or causes of action whatsoever arising out of any damage, loss or injury I might incur while participating in any of the activities contemplated by this mentoring agreement, whether such damage, loss, or injury is caused by the negligence of the Challenge Program, its officers, agents, servants, employees or otherwise.

______________________________	______________________________	__________
Mentor Print Name	Signature	Date

DPP-156
(R. 1/18)
922 KAR 1:470

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services

CENTRAL REGISTRY CHECK

FOR THE FOLLOWING TYPES OF EMPLOYMENT OR VOLUNTEERISM, STATE LAW OR KENTUCKY ADMINISTRATIVE REGULATION AUTHORIZES A CHILD ABUSE/NEGLECT (CAN) CHECK AS A CONDITION OF EMPLOYMENT OR VOLUNTEERISM. PLEASE CHECK THE CATEGORY LISTED BELOW THAT APPLIES TO YOU FOR WHICH THE CHILD ABUSE OR NEGLECT CHECK IS BEING REQUESTED:

- ☐ Child-Placing Agency (Foster/Adoption/Independent Living) Employee or Volunteer (Required by 922 KAR 1:310)
- ☐ Residential Child-Caring Facility Employee or Volunteer (Institution/Group Home/Emergency/Wilderness) (Required by 922 KAR 1:300)
- ☐ Public School Employee, Student Teacher, Contractor, or School-Based Decision-Making Council Member (Required by KRS 160.380)
- ☐ Private, Parochial, or Church School Employee or Student Teacher (Permitted by KRS 160.151)
- ☐ Youth Camp Employee, Contractor, or Volunteer (Required by KRS 194A.380-194A.383)
- ☐ Power of Attorney Regarding the Care and Custody of a Child (Required by KRS 403.352)
- ☐ Supports for Community Living (SCL) Employee (Required by 907 KAR 1:145)

Other (If none of the above categories is applicable, please explain the reason for requesting a child abuse or neglect check, including the statutory or regulatory authority for the request):
Department of Military Affairs

PERSONAL INFORMATION REGARDING THE INDIVIDUAL SUBMITTING TO A CHILD ABUSE OR NEGLECT CHECK (Please print and submit identifying information such as a copy of your driver's license, social security card, or birth certificate):

NAME: ____
(first) (middle) (maiden/nickname) (last)

Sex: ___ **Race:** _________ **Date of Birth:** _________________ **Social Security #:**___________________________

Date of Initial Hire: _______________________

Present Address: ____
City State Zip Code

Previous Address: ____
City State Zip Code

Previous Address: ____
City State Zip Code

Previous Address: ____
City State Zip Code

Previous Address: ____
City State Zip Code

Please list your addresses for the last five years. Use another sheet of paper, if necessary.

CENTRAL REGISTRY CHECK

I hereby authorize the Cabinet for Health and Family Services to complete a Child Abuse or Neglect check and to submit the results of the check to me and, on my behalf, to the employer or agency listed below. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

All the information provided is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud.

____ __________

Signature of the Individual Submitting to the Child Abuse or Neglect Check Date

____ __________

Witness Date

The individual authorizing a Child Abuse or Neglect check may submit a CHFS-305, Authorization to Disclose Protected Health Information form, authorizing the Cabinet for Health and Family Services to disclose additional information regarding a finding to the employer or agency listed below should the employer or agency request additional information pursuant to 922 KAR 1:510, Authorization for disclosure of protection and permanency records.

In addition to receiving the results myself, I authorize the Cabinet for Health and Family Services to share the results with the following employer or agency:

NAME OF EMPLOYER/AGENCY: Appalachian ChalleNGe Academy

ADDRESS: PO Box 539 **CITY**: Grays Knob

STATE: Kentucky **ZIP:** 40829 **PHONE:** (606) 574-0303

RESULTS OF CHILD ABUSE OR NEGLECT CHECK [FOR OFFICIAL USE ONLY]

☐ No reportable incident found in accordance with 922 KAR 1:470

☐ Substantiated child abuse found on the registry Date of substantiated finding: ____________

☐ Substantiated child neglect found on the registry Date of substantiated finding: ____________

The substantiated abuse or neglect finding relates to sexual abuse, sexual exploitation, a child fatality, near fatality, or involuntary termination of parental rights ☐ Yes ☐ No

☐ A matter subject to administrative review found in accordance with 922 KAR 1:470

CHECK CONDUCTED ON ________________**BY** ____

DPP-156
(R. 1/18)
922 KAR 1:470