

KENTUCKY YOUTH CHALLENGE

Rev. 08/13/2024

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>
vicky.a.newton.nfg@army.mil

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. Eminence Schools Statement Initial: _____
- 4-5. Applicant & Parent/Legal Guardian information sheet Initial: _____
- 6-7. Report of Medical History (Include documentation or explain questions 10 & 11) Initial: _____
8. Report of Medical History (Part 2) Initial: _____
9. Insurance Information Initial: _____
10. Legal Information (Law Violations) Initial: _____
11. Special Power of Attorney for the Authorization of Medical Care and
Medical Expense Statement Initial: _____
12. Certificate of Understanding and Release of Liability Initial: _____
13. Acknowledgment of Legal Custody & Drug, Alcohol, Pregnancy and HIV Testing Initial: _____
14. Release of Information Form Initial: _____
15. Workers Comp, Privacy Act, Unauthorized Absence & Acknowledgment of App. Initial: _____
16. Kentucky Youth ChalleNGe Communicare Counseling Survey Initial: _____
- 17-24. Mentor Application and Central Registry Check 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

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 _____

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 _____

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 _____

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)

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 & 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 threatened or attempted suicide? YES NO

When did this occur? _____

Did the child receive treatment? YES NO

***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 15 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. IF YOU CHECK ANY ITEM, PUT THE YEAR THAT THE CONDITION OCCURRED NEXT TO THE CONDITION

If this is a current condition, write **CURRENT** next to the condition. **Failure to disclose known issues could result in denial of applicant and termination of cadet if identified at a later date.**

<input type="checkbox"/> Thyroid trouble/goiter	<input type="checkbox"/> Eye/ear/nose/throat trouble	<input type="checkbox"/> Adverse reaction to medication	<input type="checkbox"/> Adoption Issues
<input type="checkbox"/> Bone/joint deformity	<input type="checkbox"/> Frequent indigestion	<input type="checkbox"/> Chronic colds or coughs	<input type="checkbox"/> Sexual Promiscuity
<input type="checkbox"/> Skin disorders	<input type="checkbox"/> Pregnant at this time	<input type="checkbox"/> Anxiety/Depression/Heavy Weeping	<input type="checkbox"/> Self-Mutilation/Cutting
<input type="checkbox"/> Sinusitis/hay fever	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Painful Joints (knee/ankle/shoulder/elbow)	
<input type="checkbox"/> Tumor/cyst/cancer	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Obsessive Compulsive Disorder	<input type="checkbox"/> Low Self-Esteem
<input type="checkbox"/> Lameness or neuritis	<input type="checkbox"/> Behavior Disorder	<input type="checkbox"/> Oppositional Defiant Disorder	<input type="checkbox"/> Discipline Problem
<input type="checkbox"/> Nervous disorder	<input type="checkbox"/> Stomach/intestinal	<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Withdrawn
<input type="checkbox"/> Bi-Polar	<input type="checkbox"/> Epilepsy/seizures/fits	<input type="checkbox"/> Asthma/shortness of breath	<input type="checkbox"/> Academic Problems
<input type="checkbox"/> Broken bones	<input type="checkbox"/> Gall bladder trouble	<input type="checkbox"/> Treated for female disorders	<input type="checkbox"/> Gaming/Internet Addiction
<input type="checkbox"/> Rupture/hernia	<input type="checkbox"/> Jaundice/hepatitis	<input type="checkbox"/> Severe tooth or gum trouble	<input type="checkbox"/> Moody
<input type="checkbox"/> Rectal disorder	<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Change in menstrual cycle	<input type="checkbox"/> Bullying
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Bleeds easily	<input type="checkbox"/> Painful/frequent urination	<input type="checkbox"/> Feeling of Guilt
<input type="checkbox"/> Coughed up blood	<input type="checkbox"/> Arthritis/rheumatism	<input type="checkbox"/> Dizziness/fainting spell	<input type="checkbox"/> Anger/Rage
<input type="checkbox"/> Anemia/Sickle Cell	<input type="checkbox"/> Recent gain/loss of weight	<input type="checkbox"/> Palpitation/pounding heart	<input type="checkbox"/> Socialization Issues
<input type="checkbox"/> Attempted suicide	<input type="checkbox"/> Liver disorder/disease	<input type="checkbox"/> Kidney stone/blood in urine	<input type="checkbox"/> Phobias
<input type="checkbox"/> Leg/feet cramps	<input type="checkbox"/> Frequent trouble sleeping	<input type="checkbox"/> Frequent/severe headaches	<input type="checkbox"/> Sibling Rivalry
<input type="checkbox"/> Recurrent back pain	<input type="checkbox"/> Diabetes/hypoglycemia	<input type="checkbox"/> Loss of finger/toe/arm/leg	<input type="checkbox"/> Uncontrollable Fears
<input type="checkbox"/> Knee/Back brace	<input type="checkbox"/> Had 1 or more children	<input type="checkbox"/> Sugar/albumin in urine	<input type="checkbox"/> Uncontrollable Behavior
<input type="checkbox"/> Head injury	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Heart trouble/murmur	<input type="checkbox"/> Severe Tantrums
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Unconsciousness	<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Difficulty Focusing
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Sleepwalker	<input type="checkbox"/> Speech/Hearing Impairment	<input type="checkbox"/> Identity Crisis
<input type="checkbox"/> Scarlet/Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Mobility Impairment	<input type="checkbox"/> Difficulty with Decisions

INSURANCE INFORMATION

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

Medical

Name of Insurance Company: _____

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 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

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. 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 GED, SAT, ACT, ASVAB, TABE or any other academics related to test.
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. 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.
6. That the Academy's policies and procedures have been explained to me and I understand what the Academy will attempt to do.
7. That I give my permission for the Academy Staff to maintain discipline by imposing disciplinary measures upon my child.
8. 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 _____



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: _____

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?

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BLUEGRASS CHALLENGE ACADEMY MENTOR APPLICATION

Every cadet at Bluegrass Challenge Academy **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 guardians may make suggestions, but the decision should be yours.

The following qualities may be used when choosing a mentor: A good listener, a person who enjoys being with teenagers; someone who is a good role model; a mature adult who really **cares about your success**.

- The mentor normally should be someone of the same sex.
- The mentor should not be a relative living in same household.
- The mentor must be **twenty-one** (21) or older.
- The mentor must not be drug or alcohol dependent.
- The mentor should not be someone with a felony arrest record.
- The mentor should be in good health.

NOTE: A criminal records check will be requested by the academy.

Were you ever charged with child abuse? YES NO

Were you ever charged with a felony? YES NO

Some good choices might be a coach, teacher, principal, counselor, neighbor, minister, good friend, etc. However, the mentor must, as a minimum, meet the above criteria.

Do you promise to be a positive role model even in hard times? YES NO

Do you have problems about ethnic, religious and /or racial differences? YES NO

Have you ever mentored a Child before? YES NO

Do you have doubts or concerns about being a mentor? YES NO

Are you aware that you need to stay in contact with the Cadet one year after he/she graduates and send a report once a month for 12 months? YES NO

Please have your prospective mentor complete the information that follows. The prospective mentor must also complete the attached Release of Information Form.

To protect the mentor's privacy of information, your mentors' application may be sealed in a separate envelope.

These forms must be returned with your completed Student application.

Please include a copy of your drivers license (front and back) with this application.

MENTOR APPLICATION CHECKLIST

- Page 2-Mentor Application
- Page 3-Mentor authorization to Release Information
- Page 4-Mentor Position Description
- Page 5-Mentor Liability Release

Do Not send a check or money order it is not required for Youth Challenge Volunteers

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 _____

**BLUEGRASS CHALLENGE ACADEMY
MENTOR APPLICATION**

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

Mentor's Last Name: _____ First Name: _____ Middle: _____

Mailing 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: (_____) _____ Driver's License # _____

E-Mail: _____ SS # _____ DOB ____/____/____

(Social is 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

Interviewed Date: _____ AMPS Initials: _____

Please list Two (2) references:

Name: _____ Phone #: _____ Email _____

Date Verified _____ Staff Initials _____

Name: _____ Phone #: _____ Email _____

Date Verified _____ Staff 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 ____/____/20____

**BLUEGRASS CHALLENGE ACADEMY
MENTOR AUTHORIZATION TO RELEASE INFORMATION**

I, _____, hereby authorize the Bluegrass Challenge Academy, 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 Bluegrass Challenge Academy.

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 the Bluegrass Challenge Academy and its agents from liability and damage that may result from the exchange of requested information between law enforcement departments and the Bluegrass Challenge Academy.

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

_____/_____/20_____
DATE

MENTOR POSITION DESCRIPTION

- **Position Summary:**

The mentor serves as a role model, friend, and advocate to a cadet for at least 14 months.

- **Working Relationship:**

Reports to Regional Mentor Coordinator.

Mentors only one cadet (unless approved by the Regional Mentor Coordinator)

- **Duties:**

Commits to spending at least 14 months in consistent contact with a cadet.

- **Responsibilities:**

Returns all requested forms promptly.

Attends a 3-4 hour Mentor Training class at the Academy site to learn how to relate effectively to cadet.

Assists the cadet with the Post Residential Action Plan (PRAP) development and discusses his or her progress of the Plan

Makes consistent contact with the cadet by phone, mail, or in person. Four contacts per month are required. At least two of these must be face-to-face during the Post-Residential Phase if within geographic proximity.

Completes a monthly mentor report on cadet's placement activities and sends to Regional Mentor Coordinator.

Observes all program policies and guidelines for mentors. Discusses violations of policies by cadets with the Regional Mentor Coordinator.

Refers the cadet to community resources as needed and helps the cadet obtain those resources.

Shares occasional informal and fun activities with his or her cadet. The mentor and cadet will jointly select and schedule the activities.

The mentor promptly informs the Regional Mentor Coordinator of problems or needs in the cadet's life or in their relationship.

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

(Print Name)

(Signature)

(Date)

**BLUEGRASS CHALLENGE ACADEMY
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

Applicant and Employee Rights under Kentucky's National Background Check Program

An applicant or employee may: (1) challenge the accuracy and completeness of any information contained in his or her criminal history report, (2) challenge the finding that he or she is the true subject on an abuse registry, or (3) appeal the finding that he or she is not eligible for hire as the result of a State and FBI criminal history check in accordance with the following instructions:

I. Challenge Requests

Pursuant to Kentucky's Criminal History Record Information User Agreement, Section 6.12, a copy of an applicant's KSP and/or FBI rap sheet may be provided to the applicant upon completion of the initial fitness determination. A written request for the rap sheet must be submitted to the OIG at the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

Upon receipt of the request, the OIG will send a copy of the applicant's rap sheet by certified mail, restricted delivery service. Applicants must show proof of identity and sign for the certified mail to obtain his or her rap sheet from the local post office.

Request to Challenge a KSP rap sheet: If an applicant believes that the information contained in his or her KSP rap sheet is incomplete or inaccurate, the applicant may contact the Kentucky State Police, Criminal Records Dissemination Section, at (502) 227-8700.

Request to Challenge an FBI rap sheet: In accordance with 28 C.F.R. 16.34, if an applicant believes that any information contained in his or her FBI rap sheet is incomplete or inaccurate, the applicant may direct his/her challenge regarding the accuracy or completeness of any entry on his/her record to:

FBI, Criminal Justice Information Services (CJIS) Division
ATTN: SCU, Mod. D-2
1000 Custer Hollow Road
Clarksburg, WV 26306

Abuse Registries: If an applicant believes that his or her name is listed on one of the following abuse registries in error, the applicant may contact the agency responsible for the registry as follows:

- **List of Excluded Individuals/Entities (LEIE)** – Contact the federal DHHS Office of Inspector General
 - <http://oig.hhs.gov/contact-us/>
- **Kentucky Nurse Aide Abuse Registry** – Contact the Kentucky CHFS Office of Inspector General
 - (502) 564-7963
- **Kentucky Caregiver Misconduct Registry** - Contact the Kentucky CHFS Ombudsman Office
 - (800) 372-2973 or (502) 564-5497
- **Kentucky Child Abuse and Neglect Registry** - Contact the Kentucky CHFS Ombudsman Office
 - (800) 372-2973 or (502) 564-5497

Out-of-state abuse registry findings must be addressed with the agency responsible for maintaining the abuse record.

Professional Licensing: If an applicant believes that his or her professional license is incorrectly reported as “not in good standing” or otherwise inactive, the applicant may contact the appropriate professional licensing board.

II. Request for Informal Review

If an applicant wishes to challenge the accuracy of the OIG's determination that the applicant is "not eligible for hire" based on the results of the applicant's criminal history check, the applicant may request an informal review as follows:

Step One: The applicant must sign, date, and send a written request for an informal review no later than 10 calendar days from the date of notice of the disqualifying offense to the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

Step Two: The applicant's written request must include a copy of official documentation verifying the disqualifying offense was dismissed or otherwise removed from the applicant's criminal history report.

*See Request for Administrative Hearing if dissatisfied with outcome of the informal review.

III. Request for Rehabilitation Review

Certain criminal offenses found upon completion of a State and FBI criminal background check are eligible for consideration under the rehabilitation review process. The rehabilitation review process allows an applicant the opportunity to demonstrate that he or she is rehabilitated and not likely to repeat the conduct that led to the disqualifying offense.

Offenses not eligible for consideration under the rehabilitation review process include the following:

1. A disqualifying felony offense that occurred less than seven (7) years prior to the date of the criminal background check;
2. Any disqualifying felony or misdemeanor offense related to abuse, neglect, or exploitation of an adult defined by KRS 209.020(4) or a child;
3. A felony or misdemeanor sexual offense;
4. Registration as a sex offender under federal law or under the law of any state; or
5. Any person who is a violent offender.

A request for rehabilitation review shall be made as follows:

1. A written request must be signed, dated, and mailed to the National Background Check Program at the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

2. Be mailed no later than 14 calendar days from the date of notice of the disqualifying offense; and
3. Be accompanied by a written explanation of each disqualifying criminal offense, including:
 - A description of the events related to the disqualifying offense;

- The number of years since the occurrence of the disqualifying offense;
- The age of the offender at the time of the disqualifying offense;
- Any other circumstances surrounding the offense;
- Official documentation showing that all fines, including court-imposed fines or restitution, have been paid or documentation showing adherence to a payment schedule, if applicable;
- The date probation or parole was satisfactorily completed, if applicable; and
- Employment and character references, including any other evidence demonstrating the ability of the individual to perform the employment responsibilities and duties competently.

*See Request for Administrative Hearing if dissatisfied with outcome of the rehabilitation review.

IV. Request for Administrative Hearing

An applicant may appeal the results of an informal review or rehabilitation review by submitting a written request for an administrative hearing to the Office of Ombudsman at the address provided below. The request must be submitted within 30 calendar days of notice of the decision from the informal review or rehabilitation review.

The request for an administrative hearing must be signed, dated, and mailed to the following address:

Attn: Office of Ombudsman
Cabinet for Health and Family Services
275 East Main Street, 1E-B
Frankfort, Kentucky 40621

Applicant Pre-Screening Form

(Please Type or Print Clearly)

The Applicant must provide this information before an application can be processed in the Kentucky Applicant Registry and Employment Screening (KARES) System

Declarations: By signing this form I consent to registry screening and submission of my fingerprints to the Kentucky State Police (KSP) for forwarding to the Federal Bureau of Investigation for the purpose of conducting a state and national criminal history records check pursuant to The Affordable Care Act¹ (ACA) Subtitle C, Section 6201 and pursuant to 906 KAR 1:190E. I understand that the results will be shared with the Kentucky National Background Check Program (KYNBCP) operated by the Cabinet for Health and Family Services – Office of Inspector General (CHFS-OIG).

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

I understand that as part of my application for employment or licensing, my fingerprints will be used to check the criminal history records of the Department of Kentucky State Police. I hereby give authority and consent to the Department of Kentucky State Police to retain my fingerprints and process future searches (including latent fingerprint searches) against them and make full use of them in any criminal prosecution under state or federal law. I also authorize and consent to the Department of Kentucky State Police notifying the Cabinet for Health and Family Services of subsequent arrests or convictions indicated in the criminal history records concerning me for use in determining my eligibility for employment or licensure. This authorization is given freely and voluntarily by me without coercion, duress, or threats of any kind.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

My signature acknowledges that I have read, understand and accept the terms and conditions outlined in this form.

Name of Facility or Employer: **Bluegrass Challenge Academy**

Address of Employer: **114 Conroy Ave. Ft Knox KY, 40121**

Applicant's Last Name:		Applicants First and Middle Names:	
Maiden Name:	Social Security Number:	Date of Birth:	Gender:
Government Issued ID (Include No. & Type):		State or Agency of Issue:	
Race:	Eye Color:	Hair Color:	Height (feet & inches):
Weight (lbs):	U.S. Citizen (Yes/No):	Place of Birth:	
Phone Number:	Phone Number Type:	Email Address:	
Current Physical Address Line One:		Current Physical Address Line Two:	
City:	State:	Zip Code:	County:
Current Mailing Address (if different):		City:	State:
Zip Code:	County:	Alt Phone Number:	Alt Phone Number Type:

List all residences you have lived at during the past seven years; include the timeframe in year from and year to format: (Use additional sheets if needed)

Complete Address	Year From	Year To

List all cities and states where you have worked during the past seven years; include the timeframe in year from and year to format: (Use additional sheets if needed)

City	State	Year From	Year To

List any aliases and other names you have ever used; including any other dates of birth and social security numbers: (Use additional sheets if needed)

First Name	Middle Name	Last Name	Date of Birth	Social Security Number

Have you ever been convicted of a crime? Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box for each conviction. Please provide the following: (1) offense(s) for which you were convicted; (2) the date of the conviction(s); (3) the state or territory where the conviction(s) occurred; (4) the court; and (5) any action(s) taken by the court against you, including any sentence, or probation imposed. (Use additional sheets if needed)

Do you have any charges (pending) against you for a crime? Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box for each charge. Please provide the following: (1) offense(s) for which you were charged; (2) the date of the conviction(s); (3) the state or territory where the conviction(s) occurred; (4) the court; and (5) any action(s) taken by the court against you, including any sentence, or probation imposed. (Use additional sheets if needed)

Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Has any government agency (other than the police) ever found that you abused an elderly person? Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes No

→ If yes, explain, including credential name, laminations or restrictions and time period.

Answering "NO" to all questions does not guarantee employment.

SIGNATURE, CERTIFICATION AND RELEASE OF INFORMATION

YOU MUST SIGN THIS FORM. Please read the following acknowledgements carefully before you sign.

I understand that information requested regarding gender, race, height, eye color, hair color, weight, place of birth, citizenship and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law.

I understand that a false statement on any part of this form is grounds for either not hiring me, or firing me after I begin work. I consent to the release of information regarding a criminal history on me by the Kentucky State Police, Federal Bureau of Investigation (FBI), and any of its authorized agents. I certify that, to the best of my knowledge and belief, all of my statements are true, correct and complete.

Applicant's Signature:	Signature of Parent or Guardian if Under Age 18:	
Signature of Authorized Personnel at Hiring Facility:	Title:	Today's Date:

DISCLOSURES TO BE PROVIDED TO AND SIGNED BY APPLICANT FOR EMPLOYMENT OR LICENSURE

Kentucky National Background Check Program (KY-NBCP)
Office of Inspector General, Cabinet for Health and Family Services

FOR THIS TYPE OF EMPLOYMENT OR LICENSURE, STATE AND FEDERAL LAW REQUIRE A STATE AND NATIONAL CRIMINAL BACKGROUND CHECK AS A CONDITION OF EMPLOYMENT

By signing this notice of required disclosures, the applicant for employment, volunteer services, or professional licensure, has the responsibility to be aware of the following:

(1) A set of the applicant's fingerprints will be required to complete a background check under the Kentucky National Background Check Program (KY-NBCP).

(2) The applicant must complete and sign the Waiver Agreement and Statement (OIG 1:190-2), and provide a government-issued form of identification containing the applicant's photograph (such as a valid driver's license).

(3) A background check facilitated by the KY-NBCP shall include a:

(a) Check of required abuse registries;

(b) Check of licensing board data, if applicable, to validate licensure status; and

(c) Fingerprint-supported state and Federal Bureau of Investigation (FBI) criminal background check, which includes a comparison of the applicant's fingerprints with any latent fingerprints that may be on file with the Department of Kentucky State Police (KSP) or the FBI. The fingerprint images will be used for all criminal justice purposes.

(4) The applicant's fingerprint images and associated information will be retained by KSP and the FBI in their databases and will be used to determine if the applicant has any criminal history information on file with the State and Federal criminal history repositories. KSP or the FBI will process future searches, including latent fingerprint searches, against the applicant's fingerprints and make full use of them in any criminal prosecution under state or federal law, as well as notify the Cabinet for Health and Family Services of subsequent arrests and convictions indicated in the criminal history repositories concerning the applicant.

(5) Upon submission by the applicant to the fingerprint-supported State and FBI criminal background check, an employer *may* choose to hire the applicant provisionally while the background check is processed. Upon completion of the criminal background check, the Cabinet for Health and Family Services, Office of Inspector General may release any record of State criminal history found in the files of the Kentucky centralized criminal history record information system to the applicant's current or prospective employer as reported on the OIG 1:190-2, Waiver Agreement and Statement.

(6) The applicant's Social Security Account Number is needed in order to keep records accurate pursuant to the Federal Privacy Act Statement, which may be downloaded at: <http://www.fbi.gov/about-us/cjis/cc/library/privacy-act-statement-1>

(7) All information provided to the KY-NBCP, Office of Inspector General, Cabinet for Health and Family Services shall be kept confidential in compliance with applicable state and federal laws and regulations.

(8) The applicant has the right to request and inspect his or her criminal history record and to request correction of any inaccurate information. If the applicant does not exercise his or her right to inspect criminal history information, the Commonwealth shall not be responsible for the dissemination of inaccurate information, or liable for damages resulting from its determination of the applicant's eligibility for employment.

I HAVE READ, AND UNDERSTAND, THE FOREGOING DISCLOSURES.

Printed Name of Applicant: _____

Date of Birth: _____ Last Four Digits of SSN: _____

Signature: _____ Date: _____

Kentucky National Background Check Program (KY-NBCP)
Office of Inspector General, Cabinet for Health and Family Services

WAIVER AGREEMENT AND STATEMENT

Pursuant to the 906 KAR 1:190, Kentucky National Background Check Program, this form must be completed and signed by every prospective or current employee, volunteer, licensee, and contractor/vendor for whom fingerprint-based criminal history records are requested by a qualified entity.

I, the undersigned applicant, hereby authorize _____ (hereinafter "qualified entity") to request submission of a set of my fingerprints to the Department of Kentucky State Police (KSP) and Federal Bureau of Investigation (FBI) for the purpose of accessing and reviewing state and national criminal history records that may pertain to me. By signing this Waiver Agreement and Statement, it is my intent to authorize the dissemination of any Kentucky and national criminal history record that may pertain to me to the Kentucky Cabinet for Health and Family Services, Office of Inspector General (hereinafter "OIG") for the purpose of determining whether I am eligible for employment, licensing, serving as a volunteer, or working as a contractor/vendor under 906 KAR 1:190. I further authorize the OIG to release any record of State criminal history found in the files of the Kentucky centralized criminal history record information system to the above-named qualified entity. I understand that the OIG cannot disseminate any national criminal history record from the FBI to the above-named qualified entity pursuant to 28 C.F.R. 50.12.

I further understand that, until the criminal history background check is completed, the qualified entity may choose to hire me provisionally and deny me unsupervised access to children, the elderly, or individuals with disabilities. I understand that upon written request to the OIG, I will be provided with a copy, if any, of a KSP or FBI criminal history report received on me. I understand that the OIG will only provide my criminal history report by certified mail, restricted delivery service. To receive my criminal history report from the local post office, I understand that I must show proof of identity and provide my signature. I also understand that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before a final decision is made about my status as an employee, volunteer, or contractor/vendor. If I do not exercise my right to challenge the accuracy and completeness of any information contained in my criminal history report, I agree to hold harmless the KSP and its employees from any claim for damages arising from the dissemination of inaccurate information. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages as a result of actions taken in good faith to comply with 906 KAR 1:190, including the disqualification of an applicant or employee from employment on the basis of a disqualifying offense.

Yes, I have been convicted of, pled guilty to, entered an Alford plea or a plea of nolo contendere to, or am under indictment for, a crime. **If yes, please describe the crime(s) and the particulars on an additional sheet of paper.**

No, I have not been convicted of, pled guilty to, entered an Alford plea or a plea of nolo contendere to, and am not under indictment for, a crime.

I am a current or prospective (check one): Employee Licensee Volunteer Contractor/Vendor

Applicant Signature: _____ **Date:** _____

Applicant Printed Name: _____

Applicant Date of Birth: _____ **Applicant Social Security Number:** _____

Applicant Address: _____

TO BE COMPLETED BY THE QUALIFIED ENTITY:

ENTITY NAME:	_____
ADDRESS:	_____
ENTITY ASSIGNED OCA:	_____

KEEP FOR YOUR RECORDS

Applicant and Employee Rights under Kentucky's National Background Check Program

An applicant or employee may: (1) challenge the accuracy and completeness of any information contained in his or her criminal history report, (2) challenge the finding that he or she is the true subject on an abuse registry, or (3) appeal the finding that he or she is not eligible for hire as the result of a State and FBI criminal history check in accordance with the following instructions:

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 - <http://oig.hhs.gov/contact-us/>
- **Kentucky Nurse Aide Abuse Registry** – Contact the Kentucky CHFS Office of Inspector General
 - (502) 564-7963
- **Kentucky Caregiver Misconduct Registry** - Contact the Kentucky CHFS Ombudsman Office
 - (800) 372-2973 or (502) 564-5497
- **Kentucky Child Abuse and Neglect Registry** - Contact the Kentucky CHFS Ombudsman Office
 - (800) 372-2973 or (502) 564-5497

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Step One: The applicant must sign, date, and send a written request for an informal review no later than 10 calendar days from the date of notice of the disqualifying offense to the following address:

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Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

Step Two: The applicant's written request must include a copy of official documentation verifying the disqualifying offense was dismissed or otherwise removed from the applicant's criminal history report.

*See Request for Administrative Hearing if dissatisfied with outcome of the informal review.

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Certain criminal offenses found upon completion of a State and FBI criminal background check are eligible for consideration under the rehabilitation review process. The rehabilitation review process allows an applicant the opportunity to demonstrate that he or she is rehabilitated and not likely to repeat the conduct that led to the disqualifying offense.

Offenses not eligible for consideration under the rehabilitation review process include the following:

1. A disqualifying felony offense that occurred less than seven (7) years prior to the date of the criminal background check;
2. Any disqualifying felony or misdemeanor offense related to abuse, neglect, or exploitation of an adult defined by KRS 209.020(4) or a child;
3. A felony or misdemeanor sexual offense;
4. Registration as a sex offender under federal law or under the law of any state; or
5. Any person who is a violent offender.

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1. A written request must be signed, dated, and mailed to the National Background Check Program at the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

2. Be mailed no later than 14 calendar days from the date of notice of the disqualifying offense; and
3. Be accompanied by a written explanation of each disqualifying criminal offense, including:
 - A description of the events related to the disqualifying offense;

- The number of years since the occurrence of the disqualifying offense;
- The age of the offender at the time of the disqualifying offense;
- Any other circumstances surrounding the offense;
- Official documentation showing that all fines, including court-imposed fines or restitution, have been paid or documentation showing adherence to a payment schedule, if applicable;
- The date probation or parole was satisfactorily completed, if applicable; and
- Employment and character references, including any other evidence demonstrating the ability of the individual to perform the employment responsibilities and duties competently.

*See Request for Administrative Hearing if dissatisfied with outcome of the rehabilitation review.

IV. Request for Administrative Hearing

An applicant may appeal the results of an informal review or rehabilitation review by submitting a written request for an administrative hearing to the Office of Ombudsman at the address provided below. The request must be submitted within 30 calendar days of notice of the decision from the informal review or rehabilitation review.

The request for an administrative hearing must be signed, dated, and mailed to the following address:

Attn: Office of Ombudsman
Cabinet for Health and Family Services
275 East Main Street, 1E-B
Frankfort, Kentucky 40621