Hoosier Youth ChalleNGe Academy

10892 N. State Road 140, Knightstown, IN 46148
Toll Free: 1-866-477-0156 / Fax: 765-345-1024
Website: www.hoosieryouthchallenge.org

Hoosier Youth Challe*NG*e Academy
Cadet Application Packet

The mission of the National Guard Youth ChalleNGe Program is to intervene in the life of an at-risk youth and produce a program graduate with the values, skills, education and self-discipline necessary to succeed as an adult.

The Hoosier Youth Challe*NG*e Program is a **17 ½ month** program that is broken into a 22 week (5 1/2 month) Residential Phase and a 12 month Post Residential Phase. During the 22-week Residential Phase, Cadets work towards obtaining their Test Asessing Secondary Completion or TASC and focus on 8 Core Components in a quasi-military environment. The components are used to develop personal values, self-discipline, academic success, and healthy lifestyles, as well as, setting goals and creating a life plan. Once a Cadet graduates the Residential Phase, a 12 month Post Residential Phase begins which consist of a one-year follow-up. Graduates return to their communities and implement their life plans while being supported by a caring adult mentor who serves as their role model.

The basic qualifications for acceptance into the Hoosier Youth Challe*NG*e Academy (HYCA) program are:

1. Must be between the ages of 16-18 at time of entrance (Classes begin every **January** & **July**).
2. A high school dropout who has not attained a GED or TASC.
3. Drug Free (applicants may be tested on class start date).
4. Mentally and physically capable to participate in the program. (HYCA will make all reasonable accommodations for physical disabilities.)
5. Not in trouble with Law Enforcement (No pending felony charges or convictions).
6. An Indiana resident.
7. Must complete and submit a Hoosier Youth Challe*NG*e Cadet Application Packet; all support documentation and one (1) completed Mentor Application.
8. Parent/Legal Guardian and Applicant must attend Program Orientation.

Instructions

Please Read Carefully

The following materials must be filled out completely in order to be considered for entry into the program. Incomplete applications will not be accepted.

If you have questions about filling out the application, please contact the Hoosier Youth ChalleNGe Academy at 1-866-477-0156

We accept application on a first come first serve basis, so we urge you to submit your application as soon as possible. Classes fill up very quickly; so please do not wait until the last minute.

We recommend that you keep a copy of your entire application for your records.
DO NOT SEND YOUR ORIGINAL SUPPORT DOCUMENTS with your application.
They will be collected, copied, and returned to you at the Program Orientation that you must attend.

For further information about the Hoosier Youth Challe*NG*e Academy program please visit our website at:

www.hoosieryouthchallenge.org

The Hoosier Youth Challenge Program participates in the National School Lunch Program. USDA is an equal opportunity provider and employer.

NAME OF APPLICANT: _____
First **Middle** **Last**

HOOSIER YOUTH CHALLE*NG*E ACADEMY
CADET APPLICATION PACKET CHECKLIST

Check off each required form as it is completed.

___ 1. **Applicant Information (Page 3):** Please answer each question and provide support documentation if applicable. Please print clearly.

___ 2. **Additional Contacts ` (Page 4)** List 3 additional persons HYCA can contact in an emergency. Please indicate if that person has permission to pick up the applicant in the event you are unable.

___ 3. **Applicant Goals, Mentor Prospect (Page 5)**: Applicant must list 3 goals they would like to work toward while attending HYCA and 3 goals they would like to seek upon graduation. Each Applicant must have one completed Mentor Application submitted along with their completed Cadet Application Packet and Support Documentation (see below).

___ 4 **Applicant Legal Review (Page 6)** Applicant please answer each question as honestly as possible.

___ 5 **HYCA Medical Packet (Pages 7-12):** Must answer as honestly and completely as possible.

___ 6 **Certificate of Understanding and Release of Liability. (Page 13) Please Read carefully!** Applicant and Parent/Legal Guardian must initial and sign acknowledging that you have read and understand each and every statement.

___ 7 **Legal Guardian's Recognition of Responsibility to Pick Up a Cadet Upon Dismissal (Page 14)** Parent/Legal Guardian must initial and sign acknowledging that you have read and understand each and every statement.

___ 8 **HYCA Special Power of Attorney Authorizing Medical Care & Expenses: (Page 15)** Applicant and Parent/Legal Guardian must sign. This page must ***notarized*** by a legal notary. Please do not sign this page until you are before a notary.

___ 9 **Application Packet Acknowledgement: (Page 16)** Applicant and Parent/Legal Guardian must sign. This page must ***notarized*** by a legal notary. Please do not sign this page until you are before a notary.

___ 10 **Release of Information Authorization (Page 17)** Please complete only the top half of the form with the Applicants information. Applicant and Parent/Legal Guardian must sign.

___ 11 **Limited Criminal History Authorization (Page 18)** Please complete only the top half of the form with the Applicants information. Applicant and Parent/Legal Guardian must sign.

SUPPORT DOCUMENTATION CHECK LIST

Please provide the following documentation along with your completed application. Please note that copies must be legible.
HYCA will be happy to make copies of all support documentation for you when you attend the required Program Orientation.

___ 1 **Copy of official Applicant's Birth Certificate:** Do not send original

___ 2 **Copy of Applicant's Social Security Card (or Legal Resident Documentation, if no Social Security Card):** Do not send original

___ 3 **Copy of the Applicant's Photo Identification:** Do not send originals

___ 4 **Copy of the Parent/Legal Guardian's Photo Identification:** Do not send originals

___ 5 **Proof of Parental/Legal Guardianship:** (Divorce Decree, Court Documents, Adoption Papers, etc.) if applicable.

___ 6 **Copy of Applicant's Immunization/Shot Records:** Do not send originals

___ 7 **Copy of the Front and Back of Medical Insurance Cards:** (Also Vision, Dental & RX cards). Please note: Dental work, eye exams, and medication needs must be taken care of **before** arriving to the Academy.

___ 8 **Copy of Applicant's Official School Withdrawal** from last school attended.

___ 9 **TB Test Results: (Must be completed within 60 days of class start date.)**

___ 10 One (1) completed **Mentor Application**: Applicant is responsible for providing a qualified mentor.

Incomplete applications will not be accepted!

For Official Use Only! Application Received Date: RPM Date App Entered in Database:

Regional Orientation Location: Orientation Date:

RPM Staff acknowledges that all checked documents for the application process have been received: (Initial) Date:

(Applicant please print all information) ***COUNTY OF RESIDENTS: _____ REGION: _____***

Today's Date: Month _____ Day_____ Year _____

Applicant's Social Security Number:

APPLICANT INFORMATION ONLY:

Full Legal Name: _____
(First) (Middle) (Last)

Date of Birth:_____ Age: _____ Gender: Female ___ Male ___
(MM/DD/YY)

RACE: American Indian _____ Asian _____ Black _____ White _____ Hispanic _____ Other _____

Applicant Home Phone: (_____)_____ Applicant Cell Phone: (_____)_____

Applicant Email Address: _____

Mailing Address: _____
(Street) (City) (State) (Zip Code) (County)

Previous Mailing Address: _____
(Street) (City) (State) (Zip Code) (County)

PRIMARY PARENT/LEGAL GUARDIAN CONTACT INFORMATION: (Please list additional contact persons on Page 4)

Relationship to Applicant: _____

Parent/ Legal Guardian Name:_____
(First) (Middle) (Last)

Home Phone: (_____)_____ Cell: (_____)_____ Work :(_____)_____Ext: _____

E-mail Address: _____

Mailing Address:_____
(Street) (City) (State) (Zip Code) (County)

Custody (Please select one): Parent(s)? Yes / No Legal Guardian? Yes / No

Custody Living Arrangement: Lives w/Both Parents: _____ Lives w/Mother _____ Lives w/Father _____ Lives w/LG ____

Lives w/Other: _____

Custody Agreement in place: Yes / No (*MUST* provide legal documentation of custody or proof of guardianship.)

Are there any No Contact Orders in place? Yes / No (*MUST* provide copy of documentation.)

APPLICANT INFORMATION ONLY:

Hair Color: _____ Eye Color: _____ Height:_____ Weight:_____ Shoe Size: _____ Pant Size:____ Shirt Size: _____

Appearance notes: (Please check all that apply) Tattoos ____ Body Piercings _____ Identifying Marks or Scars ____ Other:____

Please give a description of all above appearance(s) marked: _____

_____

Are you a U.S. Citizen? Yes ____ No ____ How long have you lived in IN? ___ Are you unemployed or underemployed? Yes ____ No ____

Are you married? Yes ___ No ____ Do you have any children? Yes____ No_____ How many? _____ *
***If yes, please provide copies of the necessary guardianship papers for the person that will be legally responsible for your dependent(s) while attending the Academy.**

Do you have Medical Insurance? Yes ____ No ____ Do you have Prescription Insurance? Yes ____ No ____

Do you have Vision Insurance? Yes ____ No ____ Do you have Dental Insurance? Yes ____ No ____

SCHOOL INFORMATION:

Last School Attended: _____ State: _____ County: _____

Grade Level: _____ Officially Withdrawn from School? Yes /No Date of Withdrawal: _____

HOW DID YOU LEARN ABOUT THE HOOSIER YOUTH CHALLENGE PROGRAM?

(Referred by former Cadet, hear about us online, read about us in a news article?)

_____

NAME OF APPLICANT: _____
First **Middle** **Last**

ADDITIONAL CONTACTS

Please complete all 3 boxes listed below. Do not include the Parent/Legal Guardian information listed on Page 3

3. Relationship to Applicant: _____ Emergency Contact: Primary ____ Secondary ____

Name:_____
(First) **(Middle)** **(Last)**

Mailing Address: _____
(Street) **(City)** **(State)** **(Zip Code)**

Home Phone: (_____)_____ Cell: (_____)_____ Work :(_____)_____Ext: _____

E-mail Address: _____

Custody (Please select only one): Custodial ____ Primary _____ Guardian _____ Non-Custodial _____ N/A _____

Authorized for pickup? Yes _____ No _____ Include in mailing? Yes ___No _____

4. Relationship to Applicant: _____ Emergency Contact: Primary ____ Secondary ____

Name:_____
(First) **(Middle)** **(Last)**

Mailing Address: _____
(Street) **(City)** **(State)** **(Zip Code)**

Home Phone: (_____)_____ Cell: (_____)_____ Work :(_____)_____Ext: _____

E-mail Address: _____

Custody (Please select only one): Custodial ____ Primary _____ Guardian _____ Non-Custodial _____ N/A _____

Authorized for pickup? Yes _____ No _____ Include in mailing? Yes ___No _____

4. Relationship to Applicant: _____ Emergency Contact: Primary ____ Secondary ____

Name:_____
(First) **(Middle)** **(Last)**

Mailing Address: _____
(Street) **(City)** **(State)** **(Zip Code)**

Home Phone: (_____)_____ Cell: (_____)_____ Work :(_____)_____Ext: _____

E-mail Address: _____

Custody (Please select only one): Custodial ____ Primary _____ Guardian _____ Non-Custodial _____ N/A _____

Authorized for pickup? Yes _____ No _____ Include in mailing? Yes ___No _____

NAME OF APPLICANT: _____
First **Middle** **Last**

APPLICANT RESIDENTIAL GOALS

List three goals you hope to attain while in you are in the Residential Phase of the Hoosier Youth Challe*NG*e Academy. (i.e. pass the TASC, attend the IVY Tech Class offered at HYCA, be promoted to Honor Platoon, be on Color Guard, get in physical shape, learn self-control. – please state what you hope to achieve while you are here at HYCA.).

GOAL # 1:

_____

GOAL # 2:

_____

GOAL # 3:

APPLICANT POST RESIDENTIAL GOALS

List three goals in order of preference that you would like to seek upon graduation from the Residential Phase of the Hoosier Youth Challe*NG*e Academy (i.e. join the military, go to college, attend a vocational or technical school, or get a job – please state what type of job).

GOAL # 1:

_____

GOAL # 2:

_____

GOAL # 3:

APPLICANT MENTOR PROSPECT

The Post-Residential Phase of the Hoosier Youth Challe*NG*e Academy is crucial to the long-term success of the applicant (Cadet). The goal of the Post-Residential Phase is to ensure Cadets achieve their identified goals and remain free from criminal activity and substance abuse problems. **Mentors** who are committed to helping the young person they volunteer for are **indispensable** to the Post-Residential Phase, and ultimately aid in the long-term success of the Cadet.

Each Cadet Application Packet must include one completed Mentor Application in order for the Applicant to be eligible to attend the academy Applicants actively participate in the recruitment of mentors through relationships they have prior to entering the Challe*NG*e Program producing a "Friendly Match Strategy". To qualify to be a Mentor, one must be at least 23 years old, same gender as Applicant, live in same geographical area of Applicant, cannot be a parent/step-parent/legal guardian, boyfriend/girlfriend of parent/legal guardian, cannot be a sibling or live in the same household as the Applicant. Upon enrollment of the Applicant into the Academy the mentors are then screened, trained and matched during the Residential Phase. Good mentors may be found in many places: youth workers, teachers, religious leaders, coaches, business professionals, community workers, neighbors, etc.

Please list the names of two persons you are planning to ask to complete a Mentor Application and how you know them:

_____ _____
Name of Potential Mentor 1 Name of Potential Mentor 2

_____ _____
Potential Mentor 1 – Relationship to Applicant: Potential Mentor 2 – Relationship to Applicant:

NAME OF APPLICANT: ____
First Middle Last

APPLICANT LEGAL REVIEW

1.) Have you ever been involved in, investigated, arrested and/or convicted of a crime as an ADULT? YES NO
2.) Have you ever been adjudicated as a Delinquent in Juvenile Court? YES NO
3.) If NO, Go on to the next page.
4.) If YES, Please explain each arrest and/or conviction below.

Date: _______/________/_______ Location of Offense: ______________________________________
CITY COUNTY STATE

Offense/Violation: ____

What was the conviction of the offense? STATE / FEDERAL MISDEMEANOR _______ FELONY __________

Was it Juvenile or Adult Court; JUVENILE ADULT
(Circle one)

Name & Location of Court: ____

Penalty Imposed or Other Disposition / or Sentence: ______________________________________

Probation Officer's Name ______________________________ Phone Number (________) ____________________

Date: _______/________/_______ Location of Offense: ______________________________________
CITY COUNTY STATE

Offense/Violation: ____

What was the conviction of the offense? STATE / FEDERAL MISDEMEANOR _______ FELONY __________

Was it Juvenile or Adult Court; JUVENILE ADULT
(Circle one)

Name & Location of Court: ____

Penalty Imposed or Other Disposition / or Sentence: ______________________________________

Probation Officer's Name ______________________________ Phone Number (________) ____________________

Date: _______/________/_______ Location of Offense: ______________________________________
CITY COUNTY STATE

Offense/Violation: ____

What was the conviction of the offense? STATE / FEDERAL MISDEMEANOR _______ FELONY __________

Was it Juvenile or Adult Court; JUVENILE ADULT
(Circle one)

Name & Location of Court: ____

Penalty Imposed or Other Disposition / or Sentence: ______________________________________

Probation Officer's Name ______________________________ Phone Number (________) ____________________

5.) Are you currently awaiting a hearing or sentencing for any charge? YES NO
6.) Have you had any charges or convictions, if you are over 18? YES NO
7.) If YES, What is the scheduled date and time of the hearing or sentencing? DATE: _______________ TIME: _____________
8.) List the City, County and State of the hearing: CITY: ____________________ COUNTY: ______________ STATE: ______

NAME OF APPLICANT: _____
First **Middle** **Last**

HYCA MEDICAL PACKET

DO YOU HAVE OR EVER HAD:	Yes	No	If you marked yes, and the condition has been present in the last five (5) years, please explain and provide a release from your physician, date of injury or diagnosis and treatment information.
Arthritis, rheumatism or bursitis			
Asthma			
Athletes Foot/Foot trouble			
Bed wetting tendencies			
Blood in saliva or when coughing			
Bone, joint or other deformity			
Broken bones			
Car, train or air sickness			
Chemotherapy			
Chronic cough/bronchitis			
Chronic depression			
Diabetes or hypoglycemia			
Dizziness or fainting spells			
Eating disorder			
Epilepsy or seizures			
Excessive bleeding after injury or dental work			
Eye surgery to correct vision			
Frequent cramp in legs			
Frequent indigestion			
Frequent or painful urination			
Frequent or severe headaches			
Gallbladder trouble or gallstones			
Hearing loss/impaired			
Heart trouble			
Hemorrhoids or rectal disease			
Hernia			

NAME OF APPLICANT: _____
First **Middle** **Last**

DO YOU HAVE OR EVER HAD:	Yes	No	If you marked yes, and the condition has been present in the last five (5) years, please explain and provide a release from your physician, date of injury or diagnosis and treatment information.
High or low blood pressure			
Household contact with anyone who has tuberculosis			
Inability to perform certain motions			
Jaundice or hepatitis			
Kidney stone/blood in urine			
Lack vision in either eye			
Loss of finger/toe			
Loss of memory or amnesia			
MRSA or Staff Infection			
Nerve injury			
Pain or pressure in chest			
Painful or "trick" shoulder or elbow			
Palpitation or pounding heart			
Paralysis			
Period of unconsciousness			
Recent gain/loss of weight			
Recurrent back pain or any back injury			
Recurrent ear infections			
Rheumatic fever			
Scarlet fever			
Sensitivity to chemicals, dust, sunlight, etc.			
Severe tooth or gum trouble			
Shortness of breath			
Sinusitis or hay fever			
Skin diseases			
Sleep walking, bedwetting, nightmares, or talk in your sleep			
Stomach, liver, intestinal trouble			
Stutter or stammer			
Suicide attempt or plans			
Swollen or painful joints			

NAME OF APPLICANT: _____
First **Middle** **Last**

DO YOU HAVE OR EVER HAD:	Yes	No	If you marked yes, and the condition has been present in the last five (5) years, please explain and provide a release from your physician, date of injury or diagnosis and treatment information.	
Tested positive for STD's, Syphilis/Gonorrhea, AIDS, HIV, etc				
Thyroid trouble or goiter				
Tire easily				
Trick or locked knee				
Tuberculosis or positive TB test				
Tumor, grow, cyst or cancer				
Wear a brace or back support				
Wear a hearing aid				
Wear corrective lenses				
Have you ever been treated for a mental condition?				
Have you had, or have you been advised to have any operations?				
Have you been a patient in any type of hospital?				
Have you ever had any illness or injury other than those already noted?				
Have you ever had exposure to asbestos or toxic chemicals?				
Have you ever been diagnosed with a learning disability/mild retardation?				
Have you ever used illegal substances, /alcohol, or tobacco?				
ALL APPLICANTS What is your primary language?				
Recent death in the family?				
Female Applicants Only (Next 3) Are you pregnant?			Date of last Menstrual Cycle	Date of last PAP Smear
Treated for a female disorder				
Change in menstrual pattern				

Immunizations:

Please ensure you provide this application packet with a copy of a complete immunization record. All immunizations need to be current and up to date including:

Tdap (Tetanus) MCV4 (Meningococcal) EPB (series-3) HEPA (series) FLU TB (tuberculin)

Suggested vaccinations such as HPV for females are elective. Please consult your family physician.

NAME OF APPLICANT: _____
First **Middle** **Last**

ADDITIONAL MEDICAL HISTORY INFORMATION

Dietary Restrictions or Allergies: (Due to religion or allergic reaction. Please list in detail with side effects)

_____

_____

_____

_____

Medications: (Prescription and Over the Counter Medications currently being used)

	1	2	3	4
Medicine Name				
Started When				
Dosage Amount				
How Often				
Purpose				

Chronic Problems: Diseases or illnesses

(i.e. Asthma, Physical & Medical, Mental & Psychological that you must be treated for all the time)

Date Diagnosed: _____

Diagnosis/Problem: _____

Have you ever been treated by a Behavioral Professional Therapist, Psychologist, or Psychiatrist? Yes ___ No ___

Are you currently still in their care? Yes ____ No ____

Please give last date of treatment?: _____

For what reason were you treated?: Behavioral _____ Grief _____ Counseling ____

Do You Have Suicidal Tendencies? Yes ____ No ____

(If you answered yes to the previous question please provide the following information.)

Name of Treatment Facility: _____

Doctor's Name: _____

Address _____

City _____ State _____ County _____ Zip _____

Phone: (_____) _____ Fax (_____) _____

NAME OF APPLICANT: _____
First **Middle** **Last**

MEDICAL INSURANCE INFORMATION

*Do You Currently Have Medical Health Insurance? YES __ NO __

***If you do not have any health insurance, please provide us with a copy of your Parent/Legal Guardian's driver license or identification card.**

Does Your Health Plan Cover: Medical YES ____ NO ____ Vision YES ____ NO ____ Dental YES ____ NO ____

Do You Have Indiana Medicaid? YES __ NO __ Indiana Medicaid Number _____

Package_____ Medical Network _____

Do You Have An Assigned Primary Care Physician? YES ___ NO ___ *If yes, please provide contact information on Page 12

PRIMARY INSURANCE PLAN

Policy Holder Name _____ Relationship to Applicant: _____

Address_____State _____Zip Code _____

Phone (_____) _____ Date of Birth _____ SSN _____

ID # _____ Policy Account # _____

Group #_____ Plan #_____

Insurance Phone Number: (_____) _____ Fax: (_____) _____

SECONDARY INSURANCE PLAN

Policy Holder Name _____ Relationship to Applicant: _____

Address_____ State _____ Zip Code _____

Phone (_____) _____ Date of Birth _____ SSN _____

ID # _____ Policy Account # _____

Group #_____ Plan #_____

Insurance Phone Number: (_____) _____ Fax: : (_____) _____

GUARANTOR INFORMATION:
(FINANCIAL RESPONSIBLE PARTY FOR MEDICAL EXPENSES)
Parent/Legal Guardian: Please provide a copy of your ID

Relationship to Applicant _____

Last Name _____ First Name _____ MI _____

Address _____

City_____ State _____ Zip Code _____ County _____

Email _____

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Ext: _____

SSN _____ Date of Birth _____

NAME OF APPLICANT: _____
First **Middle** **Last**

LIST OF DOCTORS

PHYSICIAN:

Physician Name:_____

Address _____

City _____ State _____ County _____ Zip _____

Phone: (_____) _____ Fax (_____) _____

DENTIST:

Dentist Name:_____

Address _____

City _____ State _____ County _____ Zip _____

Phone: (_____) _____ Fax (_____) _____

OPTOMETRIST:

Optometrist Name:_____

Address _____

City _____ State _____ County _____ Zip _____

Phone: (_____) _____ Fax (_____) _____

PROOF OF MEDICAL/PREVENTATIVE CARE:

Parent/Legal Guardians, in our attempt to support the commitment you and your applicant are making to help them change their lives, the HYCA staff wants to ensure that there will not be any complications arising for conditions that can be prevented before they arrive at the academy. Medical distractions may cause Cadets to miss out on valuable training that is required to successfully graduate the program. Please help us ensure that any pre-existing injuries, surgeries, or medical concerns are taken care of before day 1 of the program. Please provide documentation of preventative health exams that have taken place within 1-year before applying to the Hoosier Youth Challe*NG*e Academy.

If an Applicant is currently receiving medical care, has an HMO, or needs to transfer a prescription, please contact HYCA Medical Department at 765-345-1014 or Fax 765-345-1017 to request the physician and pharmacy information.

NO PRESCRIPTION MEDICATION WILL BE ACCEPTED IF IT IS OLDER THAN 30 DAYS. NO EXCEPTIONS!

If the applicant takes medication(s), including over the counter, he/she must come with at least a **30 day supply**!

I certify that I have reviewed the foregoing medical information supplied by myself and my child and I certify that it is true and complete to the best of my knowledge.

_____ _____ _____
Applicant Signature **Applicant Printed Name** **Date**

_____ _____ _____
Parent/Legal Guardian Signature **Parent/Legal Guardian Printed Signature** **Date**

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CERTIFICATE OF UNDERSTANDING AND RELEASE OF LIABILITY

I, _____ Parent/Legal Guardian of, _____
(Parent/Legal Guardian's Printed First and Last Name) (Applicant's Printed First and Last Name)

having applied for enrollment with the Hoosier Youth Challe*NG*e Academy hereby certify:

That I permit my child to participate in all Academy activities which may include UNIQUE activities such as rappelling, rope courses, 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 Indiana in various types of vehicles. This release also includes all activities that might be involved with the Mentor matched by the Academy to the cadet. This release shall remain in effect for the 17 ½ month duration of both the Residential and Post-Residential program.

_____ 1. 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.

_____ 2. That the Academy has permission for my child to participate in the TASC, ASVAB, TABE or any other academics related to testing and to receive career counseling services from Academy personnel.

_____ 3. If my child becomes a danger to himself/herself, or runs away from the Academy or an event, I hereby give my permission for the personnel to take necessary measures to maintain his/her safety which may include involving Law Enforcement and/or hospitalization.

_____ 4. I understand that my child, during the course of the program, may be randomly tested for drugs or alcohol. I also, understand that a positive test result for drugs or alcohol will subject my child to immediate expulsion from the program.

_____ 5. I understand that my daughter may be tested for pregnancy during the initial drug screening and may be tested any time deemed necessary during the course of the program. Pregnancy is not a disqualifying condition, though consideration of physical risks to cadet and unborn child will be discussed.

_____ 6. That the Academy's policies and procedures have been explained to me.

_____ 7. That I give my permission for the Academy Staff to maintain discipline by imposing disciplinary measures upon my child.

_____ 8. I understand that the Academy is a "hands off" facility which means that staff will put their hands on cadets only to restrain them from causing harm to others, themselves or significant State property.

_____ 9. I understand that as a Cadet College Class participant, should my child resign or be terminated no credit hours earned will be awarded.

Furthermore, in consideration of my child's participation in the Academy, I HEREBY RELEASE the State of Indiana, 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 Indiana, National Guard, the National Guard Youth Challe*NG*e 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.

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

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LEGAL GUARDIAN'S RECOGNITION OF RESPONSIBILITY TO PICK UP A CADET UPON DISMISSAL

_____ 1. I am the parent/legal guardian of _____.
(Applicant's Printed First and Last Name)

_____ 2. I understand that if my child becomes a cadet at the Hoosier Youth ChalleNGe Academy, the Academy retains the right to dismiss my child from the Academy for a variety of reasons including, but not limited to, an inability to participate in the program, a refusal to participate in the program, medical concerns and /or behavior concerns.

_____ 3. I understand that I have a responsibility to maintain a current phone number with the Hoosier Youth ChalleNGe Academy so that I can be contacted in the event of an emergency.

_____ 4. I understand that if my child is dismissed from the Hoosier Youth ChalleNGe Academy, I have a maximum of six (6) hours to pick up my dismissed cadet. This applies even if the cadet is eighteen (18) years of age or older.

_____ 5. I understand that if I fail to pick up my dismissed cadet, the Department of Child Services (DCS) or local police may be contacted as deemed appropriate by the Hoosier Youth ChalleNGe Academy.

_____ 6. I certify that I have access to a vehicle that runs properly and will permit me to pick up my cadet within the required six (6) hour time period if my cadet is dismissed from the program.

_____ 7. I certify that I have access to sufficient gasoline to permit me to pick up my cadet within the required six (6) hour time period if my cadet is dismissed from the program.

_____
Parent/Legal Guardian Signature

_____
Parent/Legal Guardian Printed Signature

_____
Date

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HYCA SPECIAL POWER OF ATTORNEY AUTHORIZING MEDICAL CARE & EXPENSES

Appointment of Attorney-in-Fact for Obtaining Health Care

I, _____, as parent/legal guardian of _____,
(Parent/Legal Guardian's Printed First and Last Name) (Applicant's Printed First and Last Name)

a Cadet of the Hoosier Youth Challe*NG*e Academy, appoint the Hoosier Youth Challe*NG*e 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 Challe*NG*e Academy Medical Staff - Specifically, I acknowledge the medical staff at Hoosier Youth Challe*NG*e Academy consists of a Registered Nurse, two Licensed Practical Nurses 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 Indiana.

Authorization for Treatment by Medical Care Providers - Further, I specifically authorize Hoosier Youth Challe*NG*e 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 Hoosier Youth Challe*NG*e 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 Indiana.

Authorization for Distribution of Medication by Youth Challe*NG*e Cadre – Further, I specifically authorize Hoosier Youth Challe*NG*e Academy Cadre, under the instruction and supervision of Hoosier Youth Challe*NG*e 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 Hoosier Youth Challe*NG*e Academy.

Intent to Hold Harmless - It is my intent that the Hoosier Youth Challe*NG*e Academy and its lawful agents, its 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 Hoosier Youth Challe*NG*e Academy **DOES NOT** pay for medical expenses incurred by the cadet if the injuries/illnesses are caused by cadet participating in a non-sanctioned HYCA 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 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 INDIANA, COUNTY OF _____

Before me, a Notary Public in and for the State of Indiana, 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: _____

Hoosier Youth ChalleNGe Academy
10892 N. State Road 140, Knightstown, IN 46148
Toll Free: 1-866-477-0156 / Fax: 765-345-1024
Website: www.hoosieryouthchallenge.org

APPLICATION PACKET ACKNOWLEDGEMENT

WORKERS COMPENSATION STATUS

All Cadets in the program are neither considered federal employees nor are they a member of the National Guard. The participant (Cadet) shall be considered Federal employees under Subchapter 1 of Chapter 81 of Title 5, U.S. Code, for the purpose of compensation for work injuries; and for the purpose of Sections 1346(b) and Chapter 171 of Title 28, U.S. Code, and any other provision of law relating to the liability of the United States for tortuous conduct of employees of the United States. The participants shall not be considered to be in the performance of duty while not at the assigned location of training or other activity authorized in accordance with the Program Agreement except when the participant is traveling to or from the location or is on pass from that training or other activity. In computing compensation benefits for disability or death, the monthly pay of a participant shall be deemed that received under the entrance salary for a grade GS-2 Federal employee. The entitlement of a person to receive compensation for a disability shall begin on the day following the date that the person's participation in the program is terminated

PRIVACY ACT

Personal Information is required and protected under the Privacy Act of 1974. Indiana Youth Challe*NG*e 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 the application documents 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 Challe*NG*e organization, our inspectors/evaluators, or based upon requirements dictated by competent legal authority.

UNAUTHORIZED ABSENCE

I understand that all Hoosier Youth Challe*NG*e Academy 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 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 Hoosier Youth Challe*NG*e Academy of any liability due to this action. I understand Hoosier Youth Challe*NG*e Academy will take immediate steps to locate my child once the absence is identified, and will process a missing persons 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 PROGRAM ACCEPTANCE POLICY

We understand the aim and purposes of the Hoosier Youth Challe*NG*e Program. I certify that I am not a high school graduate and I do not have an alternative completion certificate, GED or TASC. To the best of our knowledge all statements made on this application are truthful. At this time I am in good health, plan to be drug free, and do not have an alcohol or substance abuse problem. I understand that as a standard at HYCA jewelry and/or body piercings are not allowed. I also understand that HYCA is a "TOBACCO FREE" Academy. 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 any necessary information it will cause denial of the application.

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

STATE OF INDIANA, COUNTY OF _____

Before me, a Notary Public in and for the State of Indiana, 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: _____

Hoosier Youth ChalleNGe Academy

10892 N. State Road 140, Knightstown, IN 46148
Toll Free: 1-866-477-0156 / Fax: 765-345-1024
Website: www.hoosieryouthchallenge.org

RELEASE OF INFORMATION AUTHORIZATION

Applicant Full Legal Name _____
(First) (Middle) (Last)

Social Security Number: _____/_____/_____ DOB: _____/_____ /19_____ Age:_____

Address: _____
(Street) (City) (State) (Zip) (County)

Driver's License Number: _____State: _____ Expiration: _____

I consent to the release of the information requested below from the staff of the Hoosier Youth Challe*NG*e Academy. I realize that this authorization shall remain effective for one year from date of signature.

_____ _____
Parent/Legal Guardian Signature Applicant Signature

_____
Date

ACADEMY USE ONLY. DO NOT WRITE IN THE SPACE BELOW

The **aforementioned** hereby authorizes the release of the following information/records to Hoosier Youth Challe*NG*e Academy:

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

To: _____ / _____
Name Title

Agency: _____ Contact Number: _____

Address: _____ Fax: _____

City: _____ State: _____ County: _____ 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. Please provide your information to the address or fax number above. Thank you.

_____ _____
HYCA Representative Printed Name Title

Contact Number (_____) _____ Date _____/_____/20_____

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LIMITED CRIMINAL HISTORY AUTHORIZATION

I, the undersigned, Applicant and/or Parent/Legal Guardian, hereby authorize and give consent to the _____County Juvenile Probation Department, County Sheriff's or Police Department
(County Name)
and/or the Juvenile Court Clerk's office of Indiana to release to the staff of the **Hoosier Youth Challe*NG*e Academy** any and all criminal history or adjudications for delinquent acts information regarding myself, as that information appears in the records.

I, hereby waive, release and surrender any and all rights to claims which I may have against the _____ County Juvenile Probation Department, Sheriff or Police Departments, and/or
(County Name)
any of the Juvenile Court Clerk's Officers or Employees of the County of _____ that may
(County Name)
arise as a result of this information.

Applicant Full Legal Name _____
(First) (Middle) (Last)

Social Security Number: _____/_____/_____ DOB: _____/_____ /_____ Age:_____

Address: _____
(Street) (City) (State) (Zip) (County)

Driver's License Number: _____State: _____ Expiration: _____

_____ _____
Parent/Legal Guardian Signature Applicant Signature

OFFICIAL USE ONLY. APPLICANT DO NOT WRITE IN THE SPACE BELOW

Date: _____ **County of:** _____

Please check which applies: **County Official Stamp Here:**

No Conviction/Criminal Record Found _____

See Attached Limited Criminal History _____

Representative Signature: _____

Representative Printed Name: _____

Note: Any criminal history information furnished is limited to felony and misdemeanor arrests affected by the officers of this County based upon name and date of birth listed above. All certified records and court records must be obtained from the County Clerk of the Courts. REV: 9/2015