Georgia Youth ChalleNGe Program

Candidate Application Instructions

Thank you for your interest in the Georgia Youth ChalleNGe Program. You have completed the first step in the application and selection process for the program by submitting the online application. Submission of the Online Application alone does not guarantee your acceptance into program.

GaYCP class selection is made by the campus staff and is based on various factors. The application & selection process considers your application for the next available class start date regardless of the campus location. You should not expect to be selected for a specific campus location.

Submission of additional required documentation:

You must submit the required documents listed below before your file can be reviewed for your eligibility and suitability into the program. Please read every page of the Candidate Application Documents carefully. Make sure that all pages are filled out completely, legibly and are signed by Parents/Guardians and Student where it is required.

If necessary, these individual GaYCP forms can be found on the Georgia Youth ChalleNGe Program website under Admissions/Required documents link. **www.georgiayouthchallenge.org**

Use this list below as a checklist of the forms you have submitted for your application consideration

- ❑ **Candidate Application Document Form**
- ❑ **Legal History Form (with copies of official court documents)**
- ❑ **Medical History Form**
- ❑ **Medical Insurance Information**
- ❑ **Mental Health Information Form**
- ❑ **A copy of your Birth Certificate**
- ❑ **Immunization Record**
- ❑ **Academic Transcripts (unofficial)**
- ❑ **School Behavioral and Attendance Records**
- ❑ **Individualized Education Plan Documentation****

(Submit only if you are requesting academic accommodations)**

- ❑ **Completed Mentor Application (completed and signed by the Mentor)**
- ❑ **A copy of your Social Security Card**
- ❑ **Your Government Issued Identification Card (Georgia ID Card, Military ID, Passport)**

SEND YOUR DOCUMENTS TO:

Georgia Youth ChalleNGe Program
Georgia National Guard
Building 40006, P.O. Box 7620
Fort Gordon, Georgia 30905

or Fax them to 706-791-5979

or e-mail them to documents@fgyca.org

Georgia Youth ChalleNGe Program

Candidate Application Documents

Print Please

The submitted documents are for the following applicant:

Applicant Information

Last Name_____ **First Name**_____ **MI**_____

Phone Number (_____**)**_____

Email_____

Date of Birth (mm/dd/yyyy) _____ **Current Age**_____

(You must be between 16 and 18 years of age as of the first day of the YCA class date for which you are applying. If not yet eligible due to your age, your file will be held in a pending status until you become eligible for enrollment)

Parent/Guardian

Last Name_____ **First Name**_____ **MI**_____

Phone Number (_____**)**_____

Email _____

NOTE: It is requested that you DO NOT submit individual images of documents with your phone due to the image quality and clarity issues. PDF documents are acceptable.

It is highly recommended that you keep a copy of your completed application documents for your personal records.

As your application documents are collected, the campus selection committee will review them and will inform you of their decision on your selection.

During this process of consideration, you may be invited to attend a Program Orientation in which you can also bring any documents needed for your application file.

Georgia Youth ChalleNGe Program

LEGAL HISTORY FORM

PLEASE READ

Applicants cannot currently be on parole or probation for other than juvenile offenses, nor not awaiting sentencing, and not under indictment, charged, or convicted of a crime that is considered a felony that could, will or has been tried in an adult court.

ANY FALSE OR MISLEADING INFORMATION COULD RESULT IN DENIAL OF YOUR APPLICATION OR TERMINATION FROM PROGRAM

Print Applicant's Name: _____

Have you ever appeared in a CRIMINAL or CIVIL COURT, including Juvenile Court, for any offense: YES____NO____Are you awaiting trial? YES_____NO_____

Have you ever been Arrested or Convicted of a Misdemeanor or Felony? YES___NO___
If yes, explain:

_____
_____
_____
_____

Are you currently on probation, house arrest, or in-home detention? YES____ NO____
If yes, explain

_____
_____
_____
_____

4- Do you have a pending court date? ○ Yes ○ No
If yes, please explain:

_____
_____
_____
_____

5- Are you currently on probation, house arrest, or in-home detention? ○ Yes ○ No
If yes, please explain:

_____
_____
_____
_____

Applicant Name_____

Please provide the following contact information below:

Name of your Probation Officer: _____

Phone: (_____)_____-_____Email Address:_____

Use this space for further explanation of your previous answers:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

To the best of my knowledge, all statements made by me on this application are truthful. At this time, I am in good health, drug free, and do not have an alcohol problem. I am not serving a sentence under auspices of any facet of the legal system and I am not on probation. I understand that this is a "DRUG & TOBACCO-FREE" Academy.

Applicant Signature:_____ Date: _____

Parent/Guardian Signature:_____ Date:_____

YOU MUST ATTACH ALL DOCUMENTS RELATING TO THE INCIDENT'S LISTED ABOVE
(disposition, or proof of outcome showing the status of charge (misdemeanor/felony)

You can submit this form with additional documents to the following:
Email: documents@fgyca.org

Georgia Youth ChalleNGe Program
MEDICAL HISTORY FORM

Applicant Name		Social Security Number	Age
Present Statement of Health	Allergies	Current Medications & Dosages	
Height	Weight	Right Handed O Left Handed O	

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.
Household contact with anyone who has tuberculosis			
Tuberculosis or positive TB test			
Blood in saliva or when coughing			
Excessive bleeding after injury or dental work			
Suicide attempt or plans			
Sleep-walking			
Wear corrective lenses			
Eye surgery to correct vision			
Lack vision in either eye			
Wear hearing aid			
Stutter or stammer			
Wear a brace or back support			
Scarlet fever			
Rheumatic fever			
Swollen or painful joints			
Frequent or severe headaches			
Dizziness or fainting spells			
Hearing loss			
STD/syphilis/gonorrhea, etc.			
Recent gain/loss of weight			
Loss of finger/toe			
Bed-wetting since age 12			
Kidney stone/blood in urine			
Diabetes or hypoglycemia			

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 include the date.
Recurrent ear infections			
Shortness of breath			
Chronic cough			
Palpitation or pounding heart			
Heart trouble			
High or low blood pressure			
Frequent leg cramps			
Frequent indigestion			
Stomach, liver, intestinal trouble			
Gall bladder trouble or gallstones			
Jaundice or hepatitis			
Broken bones			
Skin diseases			
Tumor, growth, cyst, or cancer			
Hernia			
Hemorrhoids or rectal disease			
Frequent or painful urination			
Eating disorder			
Thyroid trouble or goiter			
Arthritis, rheumatism, or bursitis			
Bone, joint, or other deformity			
Painful or “trick” shoulder or elbow			
Recurrent back pain or any back injury			
Trick or locked knee			
Foot trouble			
Nerve injury			
Paralysis			
Epilepsy or seizures			
Car, train, or air sickness			
Chronic depression			
Loss of memory or amnesia			
Periods of unconsciousness			
X-ray or any radiation therapy			
Chemotherapy			

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 include the date.	
Sinusitis or hay fever				
Asthma				
Tire easily				
Pain or pressure in chest				
Sensitivity to chemicals, dust, sunlight, etc.				
Inability to perform certain motions				
Inability to assume certain positions				
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?				
Exposure to asbestos or toxic chemicals?				
Have you ever been diagnosed with a learning disability?				
Used illegal substance / Use tobacco?				
Female Only			Date of last Menstrual Period	Date last PAP smear
Treated for a female disorder				
Change in menstrual pattern				

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete

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Parent or Guardian Signature & Date

Georgia Youth CHalleNGe Program

MEDICAL INSURANCE INFORMATION SHEET

This information sheet must be completed in order for the applicant to be enrolled in Georgia Youth ChalleNGe Program.

CANDIDATE'S BIRTH NAME:_____SSN: _____

HOME ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

PARENT/GUARDIAN NAME:_____SSN:_____

DO NOT CURRENTLY HAVE ANY TYPE OF MEDICAL INSURANCE?_____YES____NO IF YOUR ANSWER IS YES, PLEASE COMPLETE THE FOLLOWING:

ARE YOU CURRENTLY ON MEDICAID? : YES_____NO____MEDICAID ACCT#_____
COUNTY IN WHICH APPLICANT IS CURRENTLY ENROLLED:_____
MILITARY DEPENDENT? : YES____NO ____

IF YES, SPONSOR'S NAME:_____SSN:_____

HOME ADDRESS: _____

(STREET) (CITY) (STATE) (ZIP) TRICARE

ACCOUNT NUMBER: _____

SPONSOR'S MILITARY UNIT:_____UNIT PHONE: _____

PRIMARY INSURANCE:

NAME:_____POLICY NUMBER: _____

GROUP NUMBER:_____POLICY HOLDER: _____

INSURANCE COMPANY ADDRESS:

_____

(STREET) (CITY) (STATE) (ZIP)

INSURANCE COMPANY PHONE NUMBER: (____)_____

SECONDARY INSURANCE:

NAME:_____POLICY NUMBER: _____

GROUP NUMBER:_____POLICY HOLDER: _____

INSURANCE COMPANY ADDRESS:

_____

(STREET) (CITY) (STATE) (ZIP) INSURANCE

COMPANY PHONE NUMBER: (_____)_____

GaYCP Mental Health Information Form
To be completed by a medical/mental health provider

Patient Name:_____Parent Name:_____

We are requesting you to evaluate the mental readiness of this person to attend the Georgia Youth ChalleNGe Academy Program (GYCP). We want to want to ensure that the student's attendance will "do no harm." To help in this evaluation, we are providing some basic information.

GYCA is a 5-month, intense residential quasi-military program focused on discipline and academic excellence. While in a structured, disciplined environment, students will be expected to participate in the program's eight core components in: Leadership/Followership, Service to Community, Job Skills, Academic Excellence, Responsible Citizenship, Life-Coping Skills, Health & Hygiene, and Physical Fitness. While here, students live in a military dorm with upwards of 50 other individuals; follow military customs such as marching, participating in physical training 5-days per week starting at 6:00 AM, going to bed at 9:00 PM, and having their entire day regimented.

GYCP has career counselors, but it does not provide mental health counseling; therefore, it is not recommended for individuals requiring intense mental health treatment. Parents and or Guardians will be responsible for arranging any mental health follow up appointments during (2) scheduled passes. Additional days away from training could disqualify the student for graduation, having not completed the mandatory number of days of training. Contact us, if you have questions.

Please provide the following information of the student's current status

CURRENT MENTAL HEATH INFORMATION

Attending Provider:_____

Provider's Address: _____

Providers Phone: _____

Current diagnosis and date: _____

_____

_____

_____

Dates of treatment (starting date – ending date & frequency of sessions: _____

_____

_____

_____

_____

_____

CURRENT MENTAL HEATH INFORMATION

Current Medication(s) prescribed: Include dosage and frequency

1)_____

Start Date_____Purpose_____

2)_____

Start Date_____Purpose_____

3)_____

Start Date_____Purpose_____

4)_____

Start Date_____Purpose_____

Date of Next Appointment: _____

In your opinion, does the student pose a threat to himself or others?_____

In your opinion, will the student require on-going psychotherapy in addition to medication?

In your opinion, will the student be able to cope with residing in an open bay dormitory along with approximately fifty (50) students for five months with staff supervision? If no, please explain:

In your opinion, will the student be able to largely self-manage his/her behavior and willingly take medication as prescribed with minimal supervison?_____if no, please explain

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Mental Health Provider/Physician Signature_____

Date:_____

GYCP MENTOR PROSPECT

The Post-Residential Phase of the Georgia Youth ChalleNGe Program is crucial to the long-term success of graduates. The goal of the Post-Residential Phase is to ensure graduates 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 to assist, are indispensable in the Post-Residential Phase, and ultimately, to the long-term success of the graduate.

Good mentors may be found in many places: youth workers, teachers, religious leaders, coaches, business professionals, community workers, good neighbors…. It is best if the candidate already has a relationship or knows the potential mentor.

QUALIFICATIONS OF A MENTOR

- Be at least 21 years old and the same gender as the candidate.
- Must be are
- Be able to successfully pass a criminal background check.
- Not live in the same house, be a close relative, the girlfriend/boyfriend's parent, or the employer, or the candidate or his/her parents or guardian.
- Capable of being a role model who demonstrates by example the types of life-skills, work-ethics and attitudes needed to be a productive member of society.

ACADEMY'S EXPECTATION OF MENTORS

- Attend a four (4) hour mentor training session that will be provided (discussed below).
- Write cadet and provide encouragement during the five (5) month residential phase.
- Contact the graduated cadet at least once a week (face-to-face at least twice a month) during the twelve (12) month Post-Residential Phase following graduation.
- Provide guidance for social development and achievement of the graduate's goals after graduation

MENTOR TRAINING

All individuals volunteering to be a mentor; MUST ATTEND MENTOR TRAINING. Individuals will receive training in program requirements, supervision and guidance of at-risk youth, available support resources, and the actual role of a mentor. Each mentor will receive more information regarding training after the youth has been accepted. Mentors are required to attend one training session. For additional information, contact at Fort Stewart, Ms. Fisher at (912) 876-1743/1745; or at Fort Gordon, Ms. Howard at (706) 823-9274, or at Milledgeville, Ms. Bates at (478) 445-3743.

NAME OF THE STUDENT I WISH TO MENTOR: _____

MENTOR APPLICATION FORM

DATE OF BIRTH: _____ *(MUST PROVIDE IN ORDER TO PROCESS)*

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____

*ETHNICITY (Circle One): American Indian/Alaskan Asian or Pacific Islander
Black not of Hispanic Origin Hispanic Multiracial Other White not of Hispanic Origin
GENDER (Circle One): Male Female MARITAL STATUS (Circle One): Married Single Widowed
SPOUSE'S NAME:_____NUMBER OF CHILDREN: _____

EMPLOYMENT INFORMATION

OCCUPATION:_____
EMPLOYMENT STATUS (Circle One): Full-Time Part-Time Volunteer Retired Unemployed
ORGANIZATION:_____ HOW LONG EMPLOYED? _____
PHONE NUMBER: (_____)_____ FAX NUMBER: (_____)_____
EMPLOYMENT HISTORY FOR LAST FIVE (5) YEARS:
POSITION EMPLOYER HOW LONG EMPLOYED REASON FOR LEAVING

_____

_____

_____

_____

HOME ADDRESS INFORMATION

STREET ADDRESS:_____ COUNTY: _____
CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____ CELL: (_____)_____
PAGER: (_____)_____ E-MAIL:_____

DRIVING & LEGAL INFORMATION

DO YOU HAVE YOUR OWN TRANSPORTATION? Yes No
DO YOU HAVE CAR INSURANCE? Yes No
IF NO, DO YOU HAVE ACCESS TO TRANSPORTATION? Yes No WOULD
YOU BE ABLE TO ATTEND MENTOR TRAINING? Yes No HAVE YOU
EVER USED ILLEGAL DRUGS? Yes No
IF YES, WHEN AND WHAT TYPE OF DRUGS? _____

_____

THIS INFORMATION WILL BE USED FOR STATISTICAL DATA ONLY.

NAME OF THE STUDENT I WISH TO MENTOR: _____

YOUTH EXPERIENCE

HOW LONG HAVE YOU KNOWN THE CANDIDATE? _____

PLEASE EXPLAIN HOW YOU CAME TO KNOW THE CANDIDATE YOU WISH TO MENTOR: _____

_____

_____

REFERENCES---PROVIDE FOUR (4), NON-RELATED (EMPLOYER, CLERGY, FRIEND)

NAME:_____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: (_____)_____ WORK PHONE: (_____)_____

NAME:_____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: (_____)_____ WORK PHONE: (_____)_____

NAME:_____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: (_____)_____ WORK PHONE: (_____)_____

NAME:_____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: (_____)_____ WORK PHONE: (_____)_____

I do not presently have any cases pending against me in the legal system and I am in good health. I am not nor will I be, drug or alcohol-dependent during my mentorship. The information provided is true and accurate to the best of my knowledge. I will report any and all changes in my application information to Georgia Youth ChalleNGe Program.

Mentor's Signature _____Date _____

NAME OF THE STUDENT I WISH TO MENTOR: _____

Mentor Liability Release

I understand and agree that I will be the one actually spending time with my matched GYCP graduate, and that I must exercise care in supervising my mentee while we are together. I also understand and agree that I am not a Georgia Youth Challe*NG*e Program agent, and that I am responsible for choosing and conducting all activities with my mentee, and that Challe*NG*e does not retain any power to control how these activities are conducted except to require these activities to be conducted in the State of Georgia_____.
I therefore agree that Georgia Youth Challe*NG*e will not be liable for, and I agree to hold Georgia Youth Challe*NG*e 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, or Georgia Youth Challe*NG*e negligence, or otherwise.

I further release Georgia Youth Challe*NG*e 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 Georgia Youth Challe*NG*e, its officers, agents, servants, employees, or otherwise.

Mentor's Signature _____Date _____

NAME OF THE STUDENT I WISH TO MENTOR: _____

Mentor Authorization to Release Information

I,_____, hereby authorize the Georgia Youth Challe*NG*e Program, along with law enforcement departments, to conduct whatever background search that may be deemed appropriate.

This information is necessary to assist in determining my qualifications and suitability for the mentoring position I am seeking with the Georgia Youth Challe*NG*e Program.

I fully understand that the information collected may be of a sensitive, confidential, and privileged nature, and may reflect upon my suitability. I hereby release the Georgia Youth Challe*NG*e Program and its agents from the liability and damage that may result from the exchange of requested information between law enforcement departments and the Georgia Youth Challe*NG*e Program.

Full name_____Ethnicity _____

Any other name used _____

Date of birth_____Gender _____

Place of birth _____

Social Security Number (Last Four Numbers Only)_____

Length of time lived in this state _____

State where you used to live _____

Signed _____

Dated _____

For Official Use Only:

Verified through GCIC_____ **Date**_____