

**SC Youth ChalleNGe Academy**  
**P.O. Box 2808**  
**West Columbia, SC 29171**

**TO:** Prospective Students  
**FROM:** SC-YCA Director  
**SUBJECT:** Application for Admission to the SC Youth ChalleNGe Academy

Thank you for considering the South Carolina Youth ChalleNGe Academy. Please complete the enclosed application and return it to us as soon as possible. The Residential phase of the program runs in semesters of 5 1/2 months that we call cycles. Applications must be received with all records and applicants must be interviewed before the new cycle begins in order to be considered for that cycle.

The Post-Residential Phase of the program also referred to as the Mentor Phase, runs for 12 months after your child graduates from the Residential phase. During this time your child will need a mentor from your home community. The mentor will assist your child in maintaining the lifestyle changes developed during the Residential phase. You are responsible for selecting two prospective mentors. These individuals may be neighbors, family friends, coworkers, etc. Mentor prospects may not be immediate family members (aunts or uncles may be considered), members of your household or younger than 21 years of age. The mentor prospects must be the same gender as your child (male student/male mentor and female student/female mentor). Please enter your mentor prospect information on the bottom of page 8 of the student application under Mentor Selection.

We look forward to working with your child. If you have any questions, please call our admissions office at (803) 465-3265 or (803) 832-4879.

Sincerely,

**MILTON MONTGOMERY**  
**DEPUTY DIRECTOR**  
**S C YOUTH CHALLENGE ACADEMY**

*Enclosure: Application for Admission*

## Frequently Asked Questions

### ***How long is the residential phase of the program and will the cadet be allowed to come home during this time?***

The residential phase is 5 ½ months with several mandatory passes home during this period. The first weekend pass home is usually after eight weeks. The cadet may write and receive letters and cards from family and friends throughout this phase. Cadets are allowed to call home weekly after the first two weeks of enrollment.

### ***What does the program include in addition to the military structure and academic classes?***

Class pictures	Graduation ceremony with cap and gown
Class rings	Field trips
Job shadowing	Computer classes
Nondenominational church service *(voluntary)	Choir
Field day	Cookouts
Movies	Sports
Other	

### ***What are the requirements to be considered for the program?***

Applicants must be a legal resident of South Carolina.

Applicants must turn 16 years of age before the starting date of a class, and cannot turn 20 years old during a class.

Submit the application with all required records, and come to an interview.

Applicant must be willing to attend the program and participate in the military structure.

Applicants must be physically capable of participating in physical fitness.

Applicants should be academically able to work toward the GED.

Applicants must commit to being alcohol, tobacco and drug free. Cadets will be tested.

There is **zero tolerance** for gang activity.

Applicants must not have a pending court date or be convicted of a felony offense.

***View more information about our program at our website: [www.ngycp.org/site/state/scco](http://www.ngycp.org/site/state/scco)***

## **Steps for Applying**

### **Step #1:**

Discuss the program with your student after you receive your application to ensure they are open to coming in for the interview and willing to participate in the military structure if accepted.

### **Step #2:**

Complete the application packet and gather records as quickly as possible. Follow the checklist in your packet and send back all records on the checklist that applies to your student.

### **Step #3:**

Mail or fax your application with records to the admissions office. You may request your records to be mailed or faxed to us separate from the application.

### **Step #4:**

Once we receive your student's complete application and records, we will call you to schedule an interview.

### **Step #5:**

Make sure you and your student arrive on time for the interview.

### **Step #6:**

If your student is accepted you will be notified and receive your registration date and time along with an acceptance packet.

Note: This is a free program with no admissions fee. Your interview session will consist of an orientation, informational video and interview. The mentor phase of the program will be covered in more detail and you will receive the mentor applications during the interview.

The orientation and interview will provide you the opportunity to determine if the academy is the right match for your student. In turn, it gives the admissions committee the chance to meet with you and your student to gain the information needed to make a prompt placement decision.

## Checklist

You must send your completed application along with all records and medical history form. **It is your responsibility to request all records and either send back with the application or have them mailed or faxed to us.** Please refer to the checklist below. Please write neatly and answer every question. If a question does not apply to you, please indicate N/A.

### **\_\_A Completed Application (Answer all questions. Include required signatures.)**

**\_\_Completed Medical History Form (Answer all questions. Include required signatures.)** *Provide current medical records for conditions related to cardiac, respiratory, seizures, kidney problems, recent surgeries, pregnancy, orthopedic limitations and other limiting conditions.*

### **\_\_School Records/Information**

Transcript/Credits Earned

Standardized test results (Exit Exam, Mat 7, PACT, etc.)

School Disciplinary Record (write-ups for disciplinary infractions, suspensions and/or expulsion)

***Please contact the school for unofficial records to mail back with the application. Or you may sign a release form and ask the school to mail or fax the records to us.***

### **\_\_South Carolina Certificate of Immunization**

Up-to-date immunization with Hepatitis B Series (3), MMR (2) and Tetanus (TD) in last 10 years

### **\_\_Special Education Records for Resource or Self-contained Placements**

1. Psycho-education Evaluation and/or re-evaluation or re-evaluation review plan
2. Current IEP and Goals & Objectives
3. Initial Placement Form

### **\_\_Copy of applicant's Birth Certificate**

### **\_\_Copy of applicant's SC Driving Permit, Driver's License or SC Dept. of Transportation ID Card**

### **\_\_Copy of applicant's Social Security Card**

### **\_\_Inpatient or Outpatient Mental Health Services and/or Inpatient or Outpatient Drug/Alcohol Treatment Services (if applicable)**

1. Intake summary
2. Discharge summary
3. Treatment and medication summary
4. Recommended follow-up services

### **\_\_Department of Juvenile Justice Psychological Evaluation**

For placement at R&E, Midlands Evaluation Center, Up State Evaluation Center)

**\_\_Mentor Applications (Primary and alternate prospects)** (You will receive two packets when you come to your interview or you may download them from the website.)

### **\_\_Legal Records for any and all legal involvement, past, present or pending**

Form 5 DJJ Court History, Pre-Trial Intervention Records or Arbitration Records must be requested and sent to us. These records must list all charges past, present and pending with outcome of all court hearings to include the probation officer's name, address and telephone number and terms of probation if applicable.

**SC Youth Challenge Academy**  
Student Application

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  
(LAST, FIRST, MIDDLE)

DATE OF BIRTH: MONTH \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_ AGE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ GENDER: MALE / FEMALE

MAILING ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

COUNTY: \_\_\_\_\_

PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_

CELL NUMBER: (\_\_\_\_\_) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

Are you a legal resident of South Carolina?  Yes  No  
Are you a citizen of the United States?  Yes  No

Ethnic Group  American Indian or Alaskan Native  Asian or Pacific Islander  
 African-American  Caucasian  Hispanic  Multi Racial  
 Other, Please Specify \_\_\_\_\_

Applicant Marital Status?  Single  Married  Separated  Divorced  
Do you have any children?  Yes, Number \_\_\_\_\_  No

**PARENTS/GUARDIANS:**

**FATHER:**

**STEPFATHER OR MALE GUARDIAN:**

NAME \_\_\_\_\_

NAME \_\_\_\_\_

STREET ADDRESS/Apt# \_\_\_\_\_

STREET ADDRESS/Apt# \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_

BUSINESS PHONE (\_\_\_\_\_) \_\_\_\_\_

BUSINESS PHONE (\_\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_\_) \_\_\_\_\_

**MOTHER:**

**STEPMOTHER OR FEMALE GUARDIAN:**

NAME \_\_\_\_\_

NAME \_\_\_\_\_

STREET ADDRESS/Apt# \_\_\_\_\_

STREET ADDRESS/Apt# \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_

BUSINESS PHONE (\_\_\_\_\_) \_\_\_\_\_

BUSINESS PHONE (\_\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_\_) \_\_\_\_\_



Please check if you have any of the following educational services?    \_\_\_ IEP    \_\_\_ 504    \_\_\_ BIP    \_\_\_ PE (Psych Eval Report)

Have you ever attended Adult Education classes?    Yes            No

When? \_\_\_\_\_

Where? \_\_\_\_\_

Why did you leave Adult Education? \_\_\_\_\_

Have you had **any** involvement (school SRO, detained, arrested, tickets, DJJ, etc...) in the legal system or a pending court date?

Yes            No    List charges / reason for court date \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have an intake / probation officer?    Yes            No

Reason \_\_\_\_\_

\_\_\_\_\_

Name of Intake / Probation Officer: \_\_\_\_\_

Address of Intake / Probation Officer: \_\_\_\_\_

\_\_\_\_\_

Phone Number of Probation Officer: ( \_\_\_\_\_ ) \_\_\_\_\_



**STATEMENT OF UNDERSTANDING**

I attest that every statement I have given as a part of this application is true.

I understand that the South Carolina Youth ChalleNGe Academy does not tolerate possession or use of alcohol, drugs, tobacco products, gang activity, profanity, violent or disrespectful behavior. If selected, I will not engage in such behavior.

I understand that I am not eligible to attend if I have been convicted of a felony, or if I am currently involved in the judicial system for other than minor offenses.

I understand that if I have given false information as part of this application process, either verbal or written, I will be subject to immediate dismissal from the program.

I understand the application process to the South Carolina Youth ChalleNGe Academy is competitive and that I am competing against applicants from the state of South Carolina.

I understand that by signing this statement, I agree to put forth 100% of my energy, strength, and effort to complete the academy if selected to attend.

\_\_\_\_\_  
Print Applicant's Name

\_\_\_\_\_  
Print Parent/Guardian's Name

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

***This form requires collection and maintaining information protected by the Privacy Act of 1974 Authorized by 10 U.S.C., Section 275, 10205; and Executive Order 9397***

***The South Carolina Youth ChalleNGe Academy does not discriminate on the basis of race, color, sex, age, disability, religion or national origin.***

**Release of Confidential Information**

It is requested that any professional information you have regarding

**Print Applicant's Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_

be released to the South Carolina Youth Challenge Academy. This includes any psychological reports, medical reports, psychiatric evaluations, psychiatric hospital records, school transcripts / records to include (Individual Education Plans, psychological reports , 504's, BIP's, birth certificate, social security card, immunization records, attendance records, discipline records, etc...), legal history records and other pertinent information which schools, counselors, doctors, legal professionals or others may have.

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
PARENT/GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

**Please mail this information to:**

**South Carolina Youth ChalleNGe Academy  
Attn: Admissions  
PO Box 2808  
West Columbia, SC 29171**

**OFFICE: (803) 465-3265 / (803) 832-4879**

**FAX: (803) 832-4880**

## MEDICAL HISTORY

Name \_\_\_\_\_ Male \_\_\_\_\_ Female  
 \_\_\_\_\_  
 LAST FIRST MIDDLE  
 Date of Birth \_\_\_\_\_ Height \_\_\_\_\_  
 SSN \_\_\_\_\_ Weight \_\_\_\_\_

*Have you had problems with any of the following within the last year? Please check the answer that applies.*

<input type="checkbox"/> Anemia <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Eye/vision <input type="checkbox"/> Dental <input type="checkbox"/> Ear, nose or throat <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Dizziness or fainting <input type="checkbox"/> Headaches (chronic) <input type="checkbox"/> Headaches (migraine) <input type="checkbox"/> Sinusitis <input type="checkbox"/> Heart <input type="checkbox"/> Intestinal <input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney <input type="checkbox"/> Ulcers <input type="checkbox"/> Thyroid <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Neurological <input type="checkbox"/> Skin/diseases	<input type="checkbox"/> Sickle cell <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Head injury <input type="checkbox"/> Swollen or painful joints <input type="checkbox"/> Chronic or frequent colds <input type="checkbox"/> Recent gain/loss of weight <input type="checkbox"/> Pain/pressure in chest <input type="checkbox"/> Palpitations/pounding heart <input type="checkbox"/> High blood pressure <input type="checkbox"/> Frequent indigestion <input type="checkbox"/> Stomach <input type="checkbox"/> Liver/jaundice <input type="checkbox"/> Broken bones <input type="checkbox"/> Rupture/hernia <input type="checkbox"/> Frequent/painful urination <input type="checkbox"/> VD, Syphilis, STD <input type="checkbox"/> Arthritis <input type="checkbox"/> Bone/joint deformity <input type="checkbox"/> Recurrent back pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Mental Illness <input type="checkbox"/> Depression/excessive worry	<input type="checkbox"/> Previous surgeries <input type="checkbox"/> Adverse reaction to drug(s) <input type="checkbox"/> Allergies  <b>DO YOU</b> Wear glasses, glasses or contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No Wear a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Use other tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>HAVE YOU EVER</b> Had bleeding problems? <input type="checkbox"/> Yes <input type="checkbox"/> No Attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No Had any illnesses or injuries other than the ones listed? <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoo/piercings <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>FEMALES ONLY</b> Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Ever treated for a female disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No Use contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No
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*For each item checked yes above, please explain your answer in the space provided below.*

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_  
 \_\_\_\_\_

Have you used medication for ADD/ADHD? \_\_\_\_\_  
 Name/Dosage/Date \_\_\_\_\_  
 Reason for stopping. \_\_\_\_\_

Have you used psychotropic medications? \_\_\_\_\_  
 Name/Dosage/Date \_\_\_\_\_  
 Reason for stopping. \_\_\_\_\_

Health Insurance Company/Identification Number: \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Parent/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_