DESERT VISIONS & NEVADA SKIES YOUTH WELLNESS CENTERS

198 South Skill Center Road
P.O. Box 480
Sacaton, AZ 85147
Tel: 480-338-4867
Fax: 520-562-3415

104 Big Bend Ranch Road
P.O. Box 280
Wadsworth, Nevada 89442
Tel: 480-338-4867
Fax: 520-562-3415

Admission Application

MISSION STATEMENT

Desert Visions and Nevada Skies Youth Wellness Centers provide Native American people culturally relevant behavioral health treatment to intervene in addictive lifestyles, to assist in the development of dignity and self-respect while instilling hope and promoting wellness in adolescents, families and communities.

VISION STATEMENT

Desert Visions and Nevada Skies Youth Wellness Centers are the path to wellness for Native American youth who are in need of substance abuse treatment and other behavioral health care.

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS AND BEHAVIORAL HEALTH PROVIDERS

Please read the following information:

- We recommend that this Application for admission packet be completed by a health professional. If not completed by a health professional, please include a mental health or substance abuse evaluation.
- We encourage you to **fax** the completed Application for Admissions and to **call** and leave a message stating that a fax was sent.
  - **FAX Number: 520-562-3415**
  - **Admission/Intake Telephone number: 480-338-4867**
- A phone screen with the Patient will be performed by a medical provider as part of the admission process.
- A Patient will not be admitted to Desert Visions or Nevada Skies without a legal guardian present at the time of admission unless agreed upon by the guardian, referral source, and treatment team- and all required consents and releases have been received.
- Community service may be performed while the patient is enrolled in the Desert Visions or Nevada Skies programs.
- A patient will only be discharged to a legal guardian.

TREATMENT MODEL AND PHILOSOPHY OF CARE

The purposes of the Desert Visions & Nevada Skies Youth Wellness Centers are to support as many Patients as possible in their quest for a substance-free lifestyle. We hope to educate our Patients about the negative impact of substance use on mind, body and spirit so that they in turn may educate others.

The clinical staff at Desert Visions & Nevada Skies use the medical model in viewing alcohol dependence as a disease. Desert Visions & Nevada Skies staff is aware that social and environmental factors may contribute to stressors, which may result in substance use/abuse.

In using the biopsychosocial model, Desert Visions & Nevada Skies accepts the idea that a social problem in the life of an individual may result in psychological problems if not addressed in a timely manner. Desert Visions & Nevada Skies believes that in order to achieve the highest success a therapeutic alliance with Patients and their family is of utmost importance.

Services are individual and culturally relevant to accommodate Patients with dual diagnosis. Patients are introduced to a behavioral approach, utilizing positive reinforcement for appropriate behaviors. Staff will also redirect and provide consequences for inappropriate behaviors. Patients are taught about choices and natural consequences as a result of those choices. The goal of treatment is to better the Patient's social, emotional and behavioral realm.

The 12-step program and SMART Recovery are used as an adjunct to treatment. In addition, our Patients are taught about Relapse Prevention so as to prepare themselves for re-entry with their family or other providers.

Desert Visions & Nevada Skies Youth Wellness Centers

Admission Criteria

Criteria for Admission/Re-Admission to Desert Visions & Nevada Skies Youth Wellness Centers shall include:

1. Age range between 12 and 18.
2. Must be eligible for direct care from the Indian Health Service.
3. The Patient meets DSM-5 or ICD-10 criteria for substance abuse disorder in accordance with standardized and widely accepted criteria as diagnosed by a credentialed or licensed provider.

   There must be a primary diagnosis meeting DSM-5 or ICD-10 criteria for substance abuse or dependence.
4. Completion of a health and physical examination, done within 30 days prior to admission.
5. Desert Visions/Nevada Skies staff will complete telephone screen with applicant prior to application approval.
6. Legal guardian must accompany patient to Desert Visions/Nevada Skies on admission date to check minor into facility.

The following conditions may preclude admission to Desert Visions or Nevada Skies:

1. Medical instability - any person who is experiencing an acute medical problem that would interfere from benefiting from the treatment program.
2. Actively suicidal, homicidal and/or a history of violent behaviors sufficient to be a threat to staff or patients.
3. Actively psychotic or impairment in reality testing.
4. Refusal to participate in the treatment program.
5. Significant runaway risk – Desert Visions and Nevada Skies are not lock-down facilities.
6. Behavioral problems that would interfere with other residents' treatment.
7. Intellectually challenged (any person having an I.Q. of 70 or less) or having other equivalent cognitive deficiencies which would interfere with treatment benefits.
8. Concurrent admission of a sibling or close relative.

Desert Visions/Nevada Skies Youth Wellness Center
REQUIRED DOCUMENTS

☐ Copy of Private Insurance and/or Medicaid Card

☐ Recent Health History and Physical Exam within last 30 days

☐ Copy of Immunization Report

☐ TB or PPD placed and read within the last 12 months

☐ Copy of Social Security Card

☐ Copy of Birth Certificate (Bring original on admission)

☐ Copy of Tribal Enrollment

☐ Copy of Individual Education Plan (IEP), if applicable.

Please fax the following documents to 520-562-3415
Attention: Intake Department

Intake Department Phone Number: 480-338-4867

Location Preference: _____Desert Visions
_____Nevada Skies
_____No Preference

PLEASE PRINT LEGIBLY- USE BLACK INK

Desert Visions & Nevada Skies Youth Wellness Centers

Patient Identifying Information

Patient's Name:_____ Date of Birth_____ M [ ] F [ ] Age:_____

S.S.#: _____ Place of Birth: _____

Tribal Affiliation:_____ Degree of Indian Blood: _____ Religion: _____

Address:_____ Home Phone: _____

City:_____ State:_____ Zip: _____

PARENTS:

Mother's Name:_____ Deceased?_____

Tribal Affiliation:_____ Email: _____

Address: (if different than above) _____ Phone: _____

City:_____ State:_____ Zip:_____

Father's Name:_____ Deceased?_____

Tribal Affiliation:_____ Email: _____

Address: (if different than above) _____ Phone: _____

City:_____ State:_____ Zip:_____

EMERGENCY CONTACT Name:_____ Relationship to Patient:_____

Home/ Cell Phone: _____ Work Phone: _____ Email:_____

Legal Guardian Name:_____ Relationship to Patient:_____

Tribal Affiliation:_____ Email:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone_____

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PATIENT IDENTIFICATION	NAME (First, M.I. Last)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

Updated 08/15/19

AFTERCARE COUNSELOR:

Name and Title: _____

Name of Program: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Cell #: _____ Email: _____

PROBATION OFFICER:

Name and Title: _____

Name of Program: _____

Address: _____

City; _____ State: _____ Zip: _____

Phone#: _____ Cell #: _____ Email: _____

A. EDUCATIONAL HISTORY:

1. Name of last school attended? _____ ,City _____ , State _____

2. Is Patient still in school? Yes [ ] No [ ] Current grade _____ If No, date last attended _____

3. Has Patient been in special education classes? Yes [ ] No [ ] **Does the Patient have an IEP? Yes [ ] No [ ]**

4. Has Patient been sent home from school because of drinking or drug use? Yes [ ] No [ ]

5. Has Patient ever been suspended or expelled from school? Yes [ ] No [ ]
   Why was Patient suspended or expelled? _____

   _____

6. Is Patient having any other school problems? Yes [ ] No [ ]
   - A. Speech disorder (e.g., lisp, stutter) YES [ ] NO [ ]
   - B. Learning problems in school YES [ ] NO [ ]
   - C. Grades YES [ ] NO [ ]
   - D. Truancy YES [ ] NO [ ]

   Comments: _____

_____

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B. FAMILY/RELATIONSHIP HISTORY:

1. Are Patient's biological parents still living together? Yes [ ] No [ ]
2. If parents are separated or divorced, with whom does Patient live? Mother [ ] Father [ ] other [ ]

   If you checked "other", please list. Name(s): _____

   Relationship: _____
3. Is Patient adopted? Yes [ ] No [ ]
4. Does Patient have children? Yes [ ] No [ ]

   If so, how many? _____ Ages _____

C. LEGAL HISTORY:

1. Does Patient have any charges pending? Yes [ ] No [ ]

   If so, what are they? _____
2. Does Patient have a pending court hearing? Yes [ ] No [ ]

   If yes, when is your court date? _____
3. Is Patient court ordered to treatment? Yes [ ] No [ ]
4. Has Patient had previous arrests? Yes [ ] No [ ]

   If so what were the charges? _____
5. Has Patient been in treatment before for alcohol or drugs? Yes [ ] No [ ]

   If yes, where? _____
6. Is the Patient under Child Protective Agency care? Yes [ ] No [ ]

   If yes, what is the Child Protective Service plan? _____

   _____

   _____

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D. MEDICAL PROBLEMS AND PHYSICAL CHALLENGES:

1. Is the Patient allergic to medications, foods, insect stings, plants? YES [ ] NO [ ]
   If YES, what is Patient allergic to? _____
2. Asthma? YES [ ] NO [ ]
3. Diabetes? YES [ ] NO [ ]
4. Seizure Disorder? YES [ ] NO [ ]
5. Tuberculosis? YES [ ] NO [ ]
6. Heart Problems? YES [ ] NO [ ]
7. Hepatitis? YES [ ] NO [ ]
8. Other medical problems

   _____

   _____
9. What medications have been prescribed for the Patient? _____
10. Is the Patient pregnant? YES [ ] NO [ ] If Yes, how many weeks pregnant? _____
    Who is providing prenatal care for the Patient? _____
11. Is the Patient physically challenged? (example: does Patient use a wheelchair, crutches, etc. or have vision or hearing difficulties?) _____

E. EMOTIONAL/BEHAVIORAL:

1. Does the Patient have a history of an eating disorder? (Obesity or restrict food intake to keep weight dangerously low, or binge eat and then vomit or exercise to maintain weight?) YES [ ] NO [ ]
   If YES, describe: _____
2. Does the Patient have a history of fire setting? YES [ ] NO [ ]
   If yes, describe: _____
3. Does the Patient have a history of cruelty to animals? YES [ ] NO [ ] Describe: _____
4. History of bedwetting? YES [ ] NO [ ]
5. Has the Patient been hospitalized for emotional or mental problems? YES [ ] NO [ ]

   Hospital Location Dates of treatment Reason for Admission

   _____

   _____

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6. Has the Patient seen a psychiatrist, psychologist, counselor or traditional healer for emotional/mental problems? YES [ ] NO [ ]

7. Does the Patient have a history of self-injury or suicide attempts? YES [ ] NO [ ]
Date: Method Name of Hospital # Days in Hospital Substance Abuse Involved?

_____

_____

8. Is the Patient currently self-harmful or suicidal? YES [ ] NO [ ]

If YES, describe: _____

9. Does the Patient have a history of violence toward others: YES [ ] NO [ ] If yes, describe:

_____

a. History of violence to self? (e.g. self-choking, cutting, etc.) YES [ ] NO [ ]
Describe: _____

b. Has Patient been a victim of violence from others? YES [ ] NO [ ]
Describe: _____

10. Has the Patient ever had psychological testing completed? YES [ ] NO [ ] If YES, when? _____

11. Has the Patient been involved in a gang? YES [ ] NO [ ] If YES, which gang? _____

a. Gang Colors & Attire: _____

b. Describe the Patient's involvement with the gang: _____

_____

Has Patient used any of the following? **(Please check)**

___**Alcohol** How much and how often: _____

___**Sedative Hypnotics/ tranquilizers** (Valium, Librium, Phenobarbital, etc.)

How much and how often: _____

___**Psychotropic** (Stelazine, Cogentin, Thorazine etc.) How much and how often: _____

___**Barbiturates** (Quaaludes. Phenobarbital, Nembutal, Tuinal, Seconal)

How much and how often: _____

___**Stimulants-amphetamines** (Dexedrine, Crystal, Benzedrine, Methedrine, etc.)

How much and how often: _____

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___**Sleeping pills** If yes, what kind and how much/how often: _____

___**Opiates** (heroin, morphine, opium, etc.) Specify and how much/how often:_____

___**Pain killers** (Darvon, Darvocet, codeine, etc.) Specify and how much/how often :_____

___**Hallucinogens** (LSD, STP, MDA, PCP, mescaline, etc.)

Specify and how much/how often:_____

___**Cocaine** If yes, how much/how often:_____

___**Cannabis** (Marijuana) If yes, how much/how often:_____

___**Steroids** Specify and how much/how often:_____

___**Tobacco:** Smoking [ ] How much/How often:_____

Chewing [ ] How much/How often: _____

___**Caffeine:** (Coffee, Soda) How much per day? _____

___**Inhalants** (sniffing) If yes, how much/how often:_____

___**Other** Type:_____How much and How often:_____

Has the Patient had withdrawal or severe hangovers in the past? YES [ ] NO [ ]

If YES, which substances caused withdrawal or severe hangovers _____

_____

Has the Patient had **Blackouts?** YES [ ] NO [ ] If yes please explain

_____

_____

Has the Patient had residential treatment for Substance Abuse? YES [ ] NO [ ]

Residential Facility Dates of treatment If not successfully completed, WHY?

_____

_____

Has the Patient had outpatient treatment for Substance Abuse? YES [ ] NO [ ]

Outpatient Program Counselor Dates of treatment If not successfully completed, WHY?

_____

_____

_____

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F. Other Issues the Patient may need help with:

1. Delinquent (arrested or referred to juvenile court) YES [ ] NO [ ]
2. Run away YES [ ] NO [ ]
3. Juvenile Detention YES [ ] NO [ ]
4. Depression YES [ ] NO [ ]
5. Stealing YES [ ] NO [ ]
6. Possession of weapons YES [ ] NO [ ]

G. TREATMENT ACCEPTANCE/RESISTANCE

Is the Patient willing to come to treatment voluntarily? YES [ ] NO [ ]

H. RECOVERY ENVIRONMENT

1. Who currently lives in the home with the Patient? (list names, ages and relationship to Patient)

_____

_____

_____

2. Is there anyone currently living in the Patient's home who is in poor health? YES [ ] NO [ ]
   If YES, describe condition: _____

3. Is there anyone currently living in the Patient's home who is an active substance abuser? YES [ ] NO [ ]
   If YES, relationship and substance abused: _____

4. Is there anyone currently living in the Patient's home who is active in a program of recovery? YES [ ] NO [ ]
   If YES, relationship and circumstances: _____

5. Does the Patient have access to an Aftercare Program? YES [ ] NO [ ]
   If yes, what organization and contact person? _____

6. What are the current plans for the Patient after treatment?

Living Situation: _____

_____

School Work: _____

_____

Aftercare Program: _____

_____

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7. What is the family expectation of the Patient? _____

8. Family Strengths: _____

9. Family Liabilities: _____

10. Additional Information: _____

_____

_____

11. Explain why Outpatient Treatment is not sufficient at this time: _____

_____

_____

_____

_____

12. **Patient is being referred to DESERT VISIONS or NEVADA SKIES by:**

[ ] Aftercare Counselor [ ] Probation Officer [ ] Tribal Court [ ] Behavioral Health

[ ] County Court [ ] School [ ] Family Doctor [ ] Attorney [ ] Parent

_____ _____

Print Name **Relationship to Patient**

_____ _____

Signature **Date**

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Desert Visions & Nevada Skies Youth Wellness Centers

Inventory Check List (Females at Desert Visions)

Clothing: **Absolutely NO gang colors or lettering: NO RED or BLUE. No alcohol/drug/gambling-related logos or skulls on any clothing.**

____1 Jacket or Sweater for hiking and outdoor activities
____7 Shirts or T-shirts, plain White. No tank tops or tube tops allowed except under t-shirt. **No lettering or pictures and no RED or BLUE colors.**
____7 Pairs jeans or slacks that fit – **Not oversized or too tight.**
____7 Pair Shorts when weather is warm. No "short shorts" or Cut-offs. Shorts must be **no shorter than 4 inches** above the knee
____2 Pairs Sweat pants
____2 Pairs of Athletic shoes: **NO Red or Blue markings. No clogs or sandals**
____Shower shoes: (flip-flops or slides)
____7 Pairs of socks
____Swimming suit (1 piece) **(No low or high cuts and no red or blue)**
____7 Briefs or panties (no thongs)
____5 Bras **(No underwire. Sport bras recommended)**
____Pajamas or sleeping attire
____Knee length dresses/skirts/dress shoes (optional)

Personal Hygiene: **MUST BE NEW and UNOPENED.**

____Toothbrush/toothpaste/floss: (No mouthwash containing alcohol)
____Shampoo and conditioner
____Deodorant: (non-aerosol)
____Body wash or 4 Bars Soap: (Ivory or non-perfumed hypoallergenic soap)
____Hand/body lotion
____Tampons/maxi-pads/panty liners
Additional hygiene products will be provided if needed

DO NOT bring aerosols, cologne, aftershave, body spray or hair spray or gel containing alcohol.

Personal Care:

____Medications (Prescribed only and in original bottles labeled by the pharmacist)
____Over the Counter Acne Medications (i.e. Proactive Solution)

Money, Valuables & Other:

____ **No more than $20.00 for personal items for your child.** You may add to it during your child's treatment. Desert Visions & Nevada Skies provides for expenses for special events and activities.
____ Stationery-stamps
____Small portable am/fm radio, must have earphones (bring own batteries).

"NO NO's": NO RED or BLUE. DO NOT bring belts, cameras, cell phones, iPods/Mp3 players, portable CD/DVD players, hand-held game systems, jewelry or piercings, pillows, blankets, towels, stuffed animal, food, gum, candy, weapons of any kind, or anything of value. Money and other valuable items will be kept in a locked safe. Alcohol, other drugs, and tobacco products are NOT allowed.

This Sheet may be torn from packet and given to Patient's family

Updated 08/15/19

Desert Visions & Nevada Skies Youth Wellness Centers

Inventory Check List (Males)

Clothing: Absolutely NO gang colors or lettering: NO RED or BLUE. No alcohol/drug/gambling-related logos or skulls on any clothing.

____1 Jacket or Sweatshirt for hiking and outdoor activities
_____ 7 Shirts or T-shirts, plain White. No tank top t-shirts allowed except under t-shirt. **No lettering or pictures and no RED or BLUE colors.**
____7 Pair jeans or slacks that fit – **Not oversized or too tight.**
____7 Pair shorts when the weather is warm. No "short shorts" or Cut-offs. Shorts must be **no shorter than 4 inches** above the knee
____2 Pairs Sweat pants
____2 Pairs of Athletic shoes: **NO Red or Blue markings.**
____Shower shoes: (flip-flops or slides)
____7 Pairs of socks
____Swimming trunks (No Red or Blue)
____7 briefs or boxers
____Pajamas or sleeping attire

Personal Hygiene: MUST BE NEW and UNOPENED.

____Toothbrush/toothpaste/floss: (No mouthwash containing alcohol)
____Shampoo and conditioner
____Deodorant: (non-aerosol)
____Body wash or 4 Bars Soap: (Ivory or non-perfumed hypoallergenic soap)
____Hand/body lotion

Additional hygiene products will be provided if needed

DO NOT bring aerosols, cologne, aftershave, body spray or hair spray or gel containing alcohol.

Personal Care:

____Medications (Prescribed only and in original bottles labeled by the pharmacist)
____Over the Counter Acne Medications (i.e., Proactive Solution)

Money, Valuables & Other:

____ **No more than $20.00 for personal items for your child**. You may add to it during your child's treatment. Desert Visions & Nevada Skies provides for expenses for special events and activities.
____Stationery-stamps
____Small portable am/fm radio, must have earphones (bring own batteries).

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