

**ADMISSION CHECKLIST**  
**Healing Lodge of the Seven Nations**  
**(Required at Submittal)**



1.	Completed Residential Application Form	<input type="checkbox"/>	Yes
2.	Current Substance Abuse and Drug Addiction Assessment (within 90 days)	<input type="checkbox"/>	Yes
3.	Mental Health Documents (notes, assessments, summaries, etc.) including hospital stays or Emergency Room visits within the last year	<input type="checkbox"/>	Yes
4.	Recent Physical by Physician or a Nurse Practitioner (within 3 months) – Standard physical formats are accepted. Please include current medications.	<input type="checkbox"/>	Yes
5.	Current Photo of Adolescent		
6.	TB Skin Test result (within the last 12 months)	<input type="checkbox"/>	Yes
7.	Date of Birth Verification (Birth certificate, driver’s license, state ID)	<input type="checkbox"/>	Yes
8.	Copy of Insurance Card	<input type="checkbox"/>	Yes
9.	Copy of signed patient consent form to disclose information under Title 42, Part 2, Code of Federal Regulations	<input type="checkbox"/>	Yes
10	Immunization Records	<input type="checkbox"/>	Yes
11.	Tribal Enrollment Card (if enrolled with Tribe)	<input type="checkbox"/>	Yes

***Fax or mail all information to:***

***Admissions Specialist***  
***The Healing Lodge of the Seven Nations***  
***5600 E 8<sup>th</sup> Ave***  
***Spokane Valley, WA 99212***  
***Admissions Fax: 509-535-2863***  
***Admissions Phone: 509-795-8341***  
***Admissions Toll Free #: (833)-674-2989***



## Application for Admission to the Healing Lodge of the Seven Nations

Please be complete and thorough in answering. **Any missed information will delay the processing of your application.** Please do not leave ANY blanks, if not applicable, please indicate N/A. Thank you for considering the Healing Lodge.

1) Applicant Information				
Applicant's Full Legal Name (First Middle Last)				
Date of Birth	Current Age	Birthplace (City, State)	Gender	Social Security Number
Marital Status: (Please circle one)	Divorced    Married    Separated    Single    Widowed			
Home Address: Please include this even if you have a PO box in case we need to ship something to you.				
Mailing Address _____ (Check here if same as above)				
Applicant Phone numbers to reach you at <b>(Please circle which number is best)</b>				
Home:	Cell:	Work:	Email:	
_____	_____	_____	_____	
Adolescent size of clothes for T-shirt & Sweatpants? Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large <input type="checkbox"/>				

2) Ethnicity	
Native American/Name of Tribe _____ Enrollment #: _____	<input type="checkbox"/> African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other
How many in your household are Enrolled Tribal Members? _____	
If so, which other Tribes in your household? _____	



<b>3) Legal Parent or Guardian Information</b>			
Parent or guardian's name:			
Home Address (Street address, city, state, zip): _____ Check here if same as applicant			
Parent(s)/guardian phone numbers <b>(Please circle which number is best)</b> If a work number, is it alright to call you at work? YES _____ or NO _____			
Home:	Cell:	Work:	Email:

<b>4) Emergency Contact Information</b>			
Contact Name			
Contact Address			
Contact Phone Numbers:	Home:	Cell:	Other:
Applicant Signature:			Date:

<b>5) Referent Information by: Substance Use Disorder Counselor, Behavioral Health Professional, Probation Officer, Social Worker or other Healthcare Professional</b>	
Name	Title
Name of Agency	
Mailing Address	
<b>Phone Numbers</b>	
Office:	Email
Cell:	Other Miscellaneous Information:
Fax:	
After Hours:	



6) Education History							
Years of education completed:				Name of last school:			
Current Schools Status	<input checked="" type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Suspended	<input type="checkbox"/> Expelled	<input type="checkbox"/> Dropped Out	<input type="checkbox"/> GED	
Have you ever been expelled from school?						YES	NO
Have you ever been diagnosed with a learning disorder, been involved in special education or tutoring program?						YES	NO
Do you have an IEP or 504 Plan in place? If <b>yes</b> , please provide a copy of your approved Plan.						YES	NO

7) Court Information		
Court or Agency Name that has Jurisdiction over you: _____ Check here if not applicable		
Court or Agency mailing address		
Probation Officer's Name		
Contact Phone Numbers		
Work Phone Number:	Extension Number:	Fax Number:
Cell Phone Number:	Email Address:	

8) Legal History	(Circle One)	
a) Do you have any current, pending or past legal charges? (if YES, attach charge sheet from courts)	YES	NO
b) Are you court ordered to complete treatment? <b>If so, please attach court-order.</b>	YES	NO
c) Are you required to remain in Washington State by court order or by your PO?	YES	NO
d) Do you have a history of violence?	YES	NO
e) Do you have a history of animal cruelty?	YES	NO
f) Do you have a history of fire setting?	YES	NO
g) Have you ever run away from home? Number of times: _____	YES	NO
h) Have you ever been charged with a sexual-offense?	YES	NO



9) Substance Use Disorder Treatment History				
Have you ever received substance abuse disorder treatment?			YES	NO
Program Name	Dates	Type of Discharge	If not successful, why?	

10) Mental Health Treatment History					
a) Have you ever been to a mental health counselor, psychiatrist, psychologist, etc.?			YES	NO	
Therapist Name, City, State	Dates	Reason for Therapy?			
b) Have you ever attempted Suicide?			YES	NO	
Date:		Method/Details	Number of times: _____		
			Hospitalized?	YES	NO
			Drug/Alcohol Related?	YES	NO
c) Have you every harmed yourself by cutting or burning?			YES	NO	
Date:		Method/Details	Hospitalized?		
				YES	NO
			Drug/Alcohol Related	YES	NO

11) Medical Treatment History			
Emergent-care, hospitalized, or urgent-care within the last 6 months?		YES	NO
<p><b>If so</b>, attach all records or diagnosis. <b>If not</b>, please go onto the next section.          (Please be sure to include any and all therapists, hospitals, clinics, etc. for the <i>Release of Information</i> so that if we have questions, we can speak with those medical providers.)</p>			

12) TB Screening		YES	NO
Please provide a copy of your TB Testing or Screening results. If <b>no</b> , screening can be performed at Healing Lodge.			



13) Prescribed Medication History			
Do you currently take any medications prescribed by a doctor or nurse?		YES	NO
Date prescribed	Medication used	Reason for Use	
Authorized Applicant Signature:		Date:	
Parent/Legal Guardian/Authorized Representative:		Relationship:	Date:

**14) 72-Hour Alcohol/Drug Abstinence Agreement**

The Healing Lodge does not provide detoxification services, and as such, incoming residents must refrain from any drug or alcohol use for 72 hours prior to admission. New residents exhibiting withdrawal symptoms will be evaluated by our medical staff and Substance Use Disorder Counselors for possible referral to detoxification services, if needed. If community services are not available, **you may be denied admission to the treatment program.**

By signing below, I agree not to use any alcohol or drugs for 72 hours prior to my admission appointment.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**15) TRAVEL ARRANGEMENTS**

I, \_\_\_\_\_ am the responsible party for providing round trip transportation to and from the Healing Lodge, regardless of whether or not the applicant completes treatment.

For applicants traveling more than 100 miles, if for any reason return transportation arrangements are not made for the applicant within the 24 hours of being requested, I give my permission for the Healing Lodge to make return travel arrangements for the applicant by bus, train, or airline. Permission is granted for the applicant to travel alone once arrangements are made and I agree to make arrangements to meet them at their destination.

The Healing Lodge will contact you and inform you of the transportation details. **Your signature below indicates** your understanding and agreement that the **Healing Lodge will bill you** for the full expense of return travel, and I agree to pay that expense within 30 days of notification.

Legal Parent, Guardian, or Authorized Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Guarantee Information**

**16) Insurance and Payment**

The applicant is covered by:

- Medicaid (Please list state of coverage \_\_\_\_\_)
- Private Insurance (Please attach a copy of the **front and back** of the insurance card.)
- Indian Health Service/ Contract Health Services Contact \_\_\_\_\_
- Other: (Explain) \_\_\_\_\_

I agree to be personally responsible (or if an agency representative, to commit responsibility to my agency) for any unpaid medical/dental/orthodontic/laboratory/pharmacy expenses incurred by the applicant while s/he is receiving treatment at the Healing Lodge. This includes medical and medication bills unpaid by Indian Health Services, Contract Health Services, Private Insurance and any Medicaid.

Should any bills, expenses, co-payments, or deductibles be paid by The Healing Lodge on the applicant's behalf, I agree to reimburse the Healing Lodge within 30 days of being notified of the amount due.

Legal Parent, Guardian, or Authorized Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**17) Assignment of Benefits**

I agree to assign all benefits available to me or my child through my public or private medical insurance for inpatient/residential drug and alcohol treatment to the Healing Lodge of the Seven Nations. In assigning benefits, I am authorizing my insurance carrier to make payment directly to The Healing Lodge of the Seven Nations. I also agree that any information regarding the applicant's treatment that is necessary to authorize or pay benefits, may be shared directly with the insurance carrier as needed including confidential information protected by Federal Regulations 42 CFR Part 2 and/or the Health Insurance Portability and Accountability Act (HIPAA) and this information may include chemical dependency assessments, diagnosis, and treatment records.

Print Applicant Name: \_\_\_\_\_

Legal Parent, Guardian, or Authorized Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Authorization for Release of Protected Health Information**

**The Healing Lodge of the Seven Nations**  
**Attention: Admissions Office**  
**5600 East 8th Avenue, Spokane Valley, WA 99212**  
**Fax: 509-535-5749**  
**Phone: 509-533-6910**



Applicant Name	Date of Birth

I, the above named individual, do hereby authorize the exchange of confidential and protected health information between the Healing Lodge of the Seven Nations and the following individuals or agencies. Information exchanged may be via written, faxed, verbal or secure electronic mail, pertaining to myself.

Contact person	Agency Name	Phone Number	Cell Number	Fax No.	Initials
Probation Officer					
Chemical Dependency Counselor					
Mental Health Counselor					
Attorney					
DCFS/CPS/ICW Caseworker					
Current School IEP/504 Plan					
Other					

Information exchanged is to be used to assist in my placement with The Healing Lodge of the Seven Nations treatment program. I hereby release the individuals and agency(s) listed above and their employees from liability or damages that may result from furnishing the information and/or records as requested by myself. The information released includes information protected by Federal Regulations 42 CFR Part 2, and may include medical and dental information, substance abuse and drug addiction assessments, diagnosis, and treatment records, mental health evaluation, diagnosis, and treatment records; legal history and documents; educational records; and other information that will assist in my placement at The Healing Lodge of the Seven Nations.

I understand that I may revoke this consent for release of information at any time. However, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.

This Release is in effect for 90 days from the date signed, or on: \_\_\_\_\_

Authorized Applicant Signature:	Date:
Parent/Legal Guardian/Authorized Representative:	Relationship: _____ Date: _____

## Tuberculosis Symptom Screening

Do you have any of the following symptoms?

- Cough (longer than 3 weeks)
- Coughing up blood
- Fever
- Night Sweats
- Unusual Fatigue
- Weight Loss (without trying)
- Loss of Appetite
- Shortness of Breath
- Chest Pain
- Hoarseness

Applicant Signature: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Date: \_\_\_\_\_

For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).



**PAST MEDICAL HISTORY**

Do you now or have you ever had:

- |                                                    |                                              |                                                  |
|----------------------------------------------------|----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> ADHD                    |
| <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Depression          | <input type="checkbox"/> Heart burn              |
| <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> STI's               | <input type="checkbox"/> Anemia                  |
| <input type="checkbox"/> Hypothyroidism            | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Seasonal Allergies      |
| <input type="checkbox"/> Goiter                    | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Hepatitis               |
| <input type="checkbox"/> Cancer (type) _____       | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia                  | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever         |
| <input type="checkbox"/> Psoriasis                 | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> School /Learning Problems | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> Heart problems            |                                              |                                                  |
- Other medical conditions (please list):

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**SYSTEMS REVIEW**

**In the past month, have you had any of the following problems?**

**GENERAL**

- Recent weight gain; how much \_\_\_\_\_
- Recent weight loss: how much \_\_\_\_\_
- Fatigue
- Weakness
- Fever
- Night sweats

**MUSCLE/JOINTS/BONES**

- Numbness
  - Joint pain
  - Muscle weakness
  - Joint swelling
- Where?

**EARS**

- Ringing in ears
- Loss of hearing

**EYES**

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

**THROAT**

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

**HEART AND LUNGS**

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

**NERVOUS SYSTEM**

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

**STOMACH AND INTESTINES**

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

**SKIN**

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

**BLOOD**

- Anemia
- Clots

**KIDNEY/URINE/BLADDER**

- Frequent or painful urination
- Blood in urine

**Women Only:**

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

**PSYCHIATRIC**

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

**OTHER PROBLEMS:**

**WOMENS REPRODUCTIVE HISTORY:**

Age of first period:  
 # Pregnancies:  
 # Miscarriages:  
 # Abortions:  
 Any contraception:

**Applicant Signature:** \_\_\_\_\_ **Parent Signature:** \_\_\_\_\_



## Packing List

While in treatment we will provide the following: shampoo, conditioner, lotion, lip balm, body wash, deodorant, dental floss, toothbrush, fingernail clippers, mouth wash, toothpaste, razors and shaving cream.

### ***Please plan to bring:***

- 1) Clothing, appropriate to the seasonal weather
- 2) Tee-Shirts, shorts and athletic shoes for working out/physical activity
- 3) Swimming suit/shorts (we may access off-site swimming year-round) sweat ceremony
- 4) Socks (7 total)
- 5) Underwear (7 total)
- 6) Appropriate night time sleepwear
- 7) Slippers
- 8) Jacket
- 9) Shoes (2 pairs – 1 should be tennis or running shoes)
- 10) Colder seasons (warm coat, gloves, boots) Healing Lodge will provide a winter hat.

*Note: Any shade of Red and Blue may not be worn anywhere on one's person except undergarments.*

### ***Approved Miscellaneous Items:***

- 1) Notebooks (No Spirals)
- 2) Pencils (regular & colored)
- 3) Playing cards
- 4) Coloring books

### ***Items Not Allowed:***

- 1) No personal hygiene products
- 2) Electronic devices (Cell phones, iPad, Tablets, Computers, etc.)
- 3) Cassette tapes, CD's, DVD's, Cameras or video recording devices
- 4) Make-up, nail polish and nail polish remover
- 5) Perfume, body spray & Cologne
- 6) Food, gum, candy, beverages, etc.
- 7) Metal cans, ropes, sharp objects like needles, tacks, pins, staples, etc.
- 8) Ink pens, glue, toxic marker pens, calligraphy pens, bottled ink.
- 9) Condoms
- 10) Baseball caps/hats
- 11) Magazines (books on approval only)



- 12) Razor blades, disposable blades
- 13) Personal blankets, pillows and/or stuffed animals, etc.
- 14) No jewelry (watches, necklaces, chains, rings, bracelet)
- 15) If you have tongue/nose/ear piercing, please bring only what you are wearing.
- 16) Multiple belts
- 17) We discourage bringing any item that is significant in value (ex: clothing, jackets, shoes)
- 18) No inappropriate clothing such as: crop tops, short shorts, bandanas, muscle tank tops, etc)

***Contraband List- Items not allowed at any time:***

- 1) Illicit (non-prescription) drugs or alcohol
- 2) Tobacco Products, matches, lighters, or smoking paraphernalia
- 3) Weapons of any kind (determined by Healing Lodge Staff)

***Clients should limit the number of items brought into the building. Other items not on this list may be deemed as inappropriate or dangerous by staff.***

**\*\*The Healing Lodge is not responsible for lost, traded or damaged items.**