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 **(Please circle which number is best)**				
Home: ______________________	Cell: _______________________	Work: ___________________	Email: _________________________________	
Adolescent size of clothes for T-shirt & Sweatpants? Small ☐ Medium ☐ Large ☐ X-Large ☐				

2) Ethnicity

Native American/Name of Tribe __________________________
Enrollment #: __________________________

How many in your household are Enrolled Tribal Members? _______

If so, which other Tribes in your household? ____________________________

___African American
___Asian/Pacific Islander
___Caucasian
___Hispanic
___Other

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

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

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

6) Education History						
Years of education completed:		Name of last school:				
Current Schools Status	☒Full Time	☐Part Time	☐ Suspended	☐Expelled	☐ Dropped Out	☐ 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 **yes,** 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? **If so, please attach court-order.**	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?	Number of times: _________		YES	NO
		Hospitalized?	YES	NO
Date:	Method/Details	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
If so, attach all records or diagnosis. **If not**, please go onto the next section. (Please be sure to include any and all therapists, hospitals, clinics, etc. for the *Release of Information* so that if we have questions, we can speak with those medical providers.)		

12) TB Screening	YES	NO
Please provide a copy of your TB Testing or Screening results. If **no**, 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 **<u>Healing Lodge will bill you</u>** 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: _______________

16) Insurance and Payment **Guarantee Information**

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: