Healing Lodge of the Seven Nations
Admission Application

Please mail or fax to The Healing Lodge Admissions Office along with:

- **Current Chemical Dependency Assessment** (within 90 days – please make sure that the referring chemical dependency counselor knows that we need the complete assessment – not just a summary) Please include ICD-10 codes with risk ratings.

- **Recent Physical** by a Physician or a Nurse Practitioner (within one year) – standard physical formats are accepted. Please include current medications.

- **TB Skin Test result (within the last 12 months)**

- **Immunization Records**

- **Tribal Verification** (ID or Enrollment Papers, must include date of birth, blood quantum, and enrollment number)

- **Date of Birth Verification** (Birth Certificate, driver's license, state identification card)

- **Proof of Insurance (Please ensure it's legible- please send front and back of the card)**

If applicable:

Mental Health documents (notes, assessments, summaries, etc.)
Court Order that is requiring applicant to complete treatment
Guardianship Papers
IEP (Individual Education Plan from the school)/504 Plan (from the school)

Fax or mail all information to:

Admissions Specialist
The Healing Lodge of the Seven Nations
5600 East 8th Avenue
Spokane Valley, WA 99212
Admissions Fax: 509-535-5749

Once you have submitted all of the required information of the application, it will be reviewed by the Admissions Team to make sure that the Healing Lodge's ASAM 3.5 level of care program is the most appropriate place for the applicant, and that we have the services necessary to provide a high level of service based on individual needs.

Admission Team Reviews completed application with all required documents on Tuesdays and Thursdays of each week.

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.

Applicant Information

Applicant's Full Legal Name (First Middle Last)				
Date of Birth	Current Age	Birthplace (City, State)	Gender	Social Security Number

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.
If a work number, is it alright to call you at work? ☐ YES ☐ NO

Home : Cell: Work: Other:

Ethnicity

☐ Native American (Tribe_____) ☐ Caucasian ☐ African American

☐ Alaska Native ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other

Prescribed Medication History

Do you currently take any medications prescribed by a doctor or nurse? ☐ YES ☐ NO

Date prescribed	Medication used	Reason for Use	Still Taking?

Please note - Do ***NOT*** bring any medications to the Healing Lodge, they will be provided for you by our in house pharmacy. If needed, your home pharmacy should be able to provide you with a medication history.

Parent/Guardian Information

Parent or guardian's name			
Home Address (Street address, city, state, zip. ☐ Check here if same as applicant			
Parent/guardian Phone numbers to reach you at (please indicate which is best) If a work number, is it alright to call you at work? ☐ YES ☐ NO			
Home:	Cell:	Work:	Other:

Emergency Contact Information

In the event that I cannot be reached, I designate the following individual to act on my behalf. They may consent for treatment, arrange for transportation to/from the Healing Lodge, may answer questions on my behalf, and act on my behalf while I am unavailable, or unreachable. I agree to be financially responsible for any commitments this individual may make on my behalf.

Contact Name			
Contact Address			
Contact Phone Numbers	Home:	Cell:	Other:
Relationship to Resident:			
Signature of Parent or Guardian	Date		

Legal guardian is:

◯	Mother	◯	DCFS or ICW Caseworker	◯	Aunt/Uncle	◯	Grandparents
◯	Father	◯	Adoptive Parents	◯	CPS	◯	Foster parents

Other: ◯

Please note: If the guardian is other than the mother and father, please attach any guardianship, BECCA, CHINS, or court orders with the application.

Referent Information

This person can be the referring chemical dependency or mental health counselor, probation officer, caseworker, social worker, school counselor, or other professional that is working on behalf of the applicant and family to assist with placement at the Healing Lodge. Please be sure to include them on the Release of information so that we can talk with them on the application.

Name	Title

Name of Agency

Mailing Address

Phone Numbers

Office:		Email
Cell:		Other Miscellaneous Information:
Fax:		
After Hours:		

Court Information

Court or Agency Name that has Jurisdiction over you: ☐ Check here if not applicable

Mailing Address of that Court or Agency

Probation Officer's Name

Contact Phone Numbers

Work (with extension)	Extension	Fax
Cell	Email	

Education History

Years of education completed:		Name of last school:					
Current Schools Status	☐ Full Time	☐ Part Time	☐ Suspended	☐ Expelled	☐ Dropped Out	☐ GED	

In the past twelve months, how many times have you been suspended from school?		
How many schools have you been expelled from?		
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?	☐ YES	☐ NO

If yes, please describe. Also, please contact your school and have them forward it to us as soon as possible, this will assist us in meeting your educational needs.

Legal History

Do you have any current, pending or past legal charges? (if YES, attach RAP Sheet from courts)	☐ YES	☐ NO
Are you court ordered to complete treatment?	☐ YES	☐ NO
Are you confined to remain in Washington State by court order or by your PO?	☐ YES	☐ NO
Do you have a history of violence in the last 5 years?	☐ YES	☐ NO
Explain (use another sheet of paper if necessary)		
Do you have a history of animal cruelty?	☐ YES	☐ NO
Explain (use another sheet of paper if necessary)		
Do you have a history of fire setting?	☐ YES	☐ NO
Explain (use another sheet of paper if necessary)		
Have you ever run away from home? ☐ YES ☐ NO Number of times: _____		
Have you ever been charged with a sexual offense?	☐ YES	☐ NO
Explain (use another sheet of paper if necessary)		
Have you ever attempted Suicide? (Attach another sheet of paper if necessary)	☐ YES	☐ NO

Date:	Method/Details			
		Hospitalized?	☐ YES	☐ NO
		Drug/Alcohol Related?	☐ YES	☐ NO

Have you ever harmed yourself by cutting or burning? (Attach another sheet of paper if necessary)	☐ YES	☐ NO

Date:	Method/Details			
		Hospitalized?	☐ YES	☐ NO
		Drug/Alcohol Related?	☐ YES	☐ NO

Chemical Dependency Treatment History

Have you ever received substance abuse treatment?	☐ YES	☐ NO

Program Name	Dates	Type of Discharge	If not successful, why?	Inpatient or outpatient?

Mental Health Treatment History

Have you ever been to a mental health counselor, psychiatrist, psychologist, etc?	☐ YES	☐ NO

Therapist Name	Dates	Reason for Therapy?

Please be sure to include any and all therapists, hospitals, clinics, etc to the Release of Information page so that if we have questions, we can speak with those therapists.

Authorization for the Release of Protected Health Information

The Healing Lodge of the Seven Nations
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 Number
Probation Officer				
Chemical Dependency Counselor				
Mental Health Counselor				
Attorney				
DCFS/CPS/ICW Caseworker				
Other				
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 people and agency(s) 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, chemical dependency 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 _____

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

Insurance and Payment Guarantee Info

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
☐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.

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, round trip travel will be purchased prior to admission (open ended return for bus/train/airline tickets) In lieu of this, a deposit for the amount of return travel will be deposited with the Healing Lodge. The deposit requirement will be waived if an approved agency guarantees that travel will be arranged and paid for within 24 hours of being requested.

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.

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: _____

Parent/Legal Guardian Signature:_____Date:_____

Printed Name of Signer:_____Relationship:_____

For Native American Applicants Enrolled in a Federally Recognized Tribe of Direct Descendant.

Please attach a copy of the applicants Tribal Identification or Enrollment papers. For descendants, please attach a copy of the parent or grandparent's enrollment and birth certificate(s) showing direct descendency.

Indian Health Services/Contract Health Services for Medical Care Only

If the applicant's only medical coverage is through I.H.S./Contract Services, have this part of the application signed by the Authorizing Contract Health Official.

Understanding of Agreement –Urgent and Emergent Medical Care

Print Applicant Name: _____

_____ _____

Indian Health Services/Contract Health Service Unit Name PO/Auth# (MUST HAVE TO BILL I.H.S.)

The above I.H.S./C.H.S. unit is responsible for any urgent and emergent medical and dental services (Priority 1), including prescription medication for the above named applicant while s/he is receiving inpatient treatment at the Healing Lodge of the Seven Nations (HL7N). In the event of an emergency, the above named Service Unit will be contacted within 72 hours. All non-urgent or emergent care (Priority 2) will be handled through the Indian Health Direct Service Units and/or Urban Indian Health Clinic. All Priority 3 or higher medical care will be referred back to the home I.H.S. Direct Care Service Unit.

By signing this agreement, the above named Service Unit is agreeing to pay only for urgent and emergency medical care as well as medications procured from local providers within the Spokane area, and ***NOT the daily cost of inpatient treatment*** at the Healing Lodge.

_____ _____

Signature of Authorizing Contract Health Official Date

_____

Printed Name of Contract Health Official

_____

Phone Number and Extension Fax Number Email Address

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 chemical dependency counselors for possible referral to community detoxification services, if necessary. 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 Date