



# NEVADA SKIES YOUTH WELLNESS CENTER

104 Big Bend Ranch Road

P.O. Box 280

Wadsworth, Nevada

89442

Tel: 775-352-6840

Tel: 775-352-6847

# APPLICATION

# For

# ADMISSION

## 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.
- We encourage you to **fax** the completed Application for Admissions to **775-575-3180** and **call 775-352-6847** and leave a message stating that a fax was sent
- A phone screen with the client will be performed by a Nevada Skies staff as part of the admission process.
- A client will not be admitted to Nevada Skies without a legal guardian present at the time of admission.
- Community service may be performed while the client is enrolled in the Nevada Skies program.
- A client will only be discharged to a legal guardian.

## **TREATMENT MODEL AND PHILOSOPHY OF CARE**

The purpose of the Nevada Skies Youth Wellness Center is to support as many clients as possible in their quest for a substance-free lifestyle. We hope to educate our clients about the negative impact of substance use on mind, body and spirit so that they in turn may educate others.

The clinical staff at Nevada Skies uses the medical model in viewing alcohol dependence as a disease. 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, Nevada Skies accepts the idea that a social problem in the life of an individual may result in psychological problems if not arrested in a timely manner. Nevada Skies believes that in order to achieve the highest success a therapeutic alliance with clients and their family is of utmost importance.

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

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

# Nevada Skies Youth Wellness Center

## Admission Criteria

### **Criteria for Admission/Re-Admission to Nevada Skies Youth Wellness Center shall include:**

1. Age range between 12 and 18.
2. Must be eligible for direct care from the Indian Health Service.
3. The client meets DSM IV 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 IV or ICD-10 criteria for substance abuse or dependence.
  - There may be a secondary Axis I or Axis II diagnosis. (Axis III diagnoses must be specified, including “No diagnosis”.)
4. Completion of a health and physical examination, done within 30 days prior to admission.
5. Nevada Skies staff will complete telephone screen with applicant and legal guardian prior to application approval.
6. Legal guardian must accompany client to Nevada Skies on admission date to check minor into facility.

### **The following conditions may preclude admission to 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 clients.
3. Actively psychotic or impairment in reality testing.
4. Refusal to participate in the treatment program.
5. Significant runaway risk – Nevada Skies is not a lock down facility.
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.

**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**

**Please fax the following documents to 775-575-3180**

**Attention: Intake Department**

## Nevada Skies Youth Wellness Center

### Client Identifying Information

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

Client'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: \_\_\_\_\_

Address: (if different than above) \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Deceased? \_\_\_\_\_

Tribal Affiliation: \_\_\_\_\_

Address: (if different than above) \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is the client Court Ordered to Treatment? Yes \_\_\_ No \_\_\_

What are the consequences of not completing treatment? \_\_\_\_\_

What are the consequences of AWOL (running?) \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**LEGAL GUARDIAN:**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Tribal Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**AFTERCARE COUNSELOR:**

Name and Title: \_\_\_\_\_

Name of Program: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Pager #: ( ) \_\_\_\_\_

**PROBATION OFFICER:**

Name and Title: \_\_\_\_\_

Name of Program: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Pager #: ( ) \_\_\_\_\_

**A. EDUCATIONAL HISTORY:**

1. Name of last school attended? \_\_\_\_\_, City/Town \_\_\_\_\_, State \_\_\_\_\_

Last grade completed? \_\_\_\_\_

2. Is client still in school? Yes [ ] No [ ] If No, date last attended \_\_\_\_\_

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

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

5. Has client ever been suspended or expelled from school? Yes [ ] No [ ]

Why was client suspended or expelled? \_\_\_\_\_

\_\_\_\_\_

Is client in danger of being expelled now? Yes [ ] No [ ]

Why? \_\_\_\_\_

6. Is client 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 client's biological parents still living together? Yes  No
2. If parents are separated or divorced, with whom does client live? Mother  Father  other   
 If you checked "other", please list. Name(s): \_\_\_\_\_  
 Relationship: \_\_\_\_\_
3. Is client adopted? Yes  No
4. Does client have children? Yes  No   
 If so, how many? \_\_\_\_\_ Ages \_\_\_\_\_

**C. LEGAL HISTORY:**

1. Does Client have any charges pending? Yes  No   
 If so, what are they? \_\_\_\_\_
2. Has Client had previous arrests? Yes  No   
 If so what were the charges? \_\_\_\_\_
3. **Being referred to Nevada Skies by:**  
 Aftercare Counselor     Probation Officer     Tribal Court     Behavioral Health  
 County Court     School     Family Doctor     Attorney     Parent
4. Does Client have a Pending Court Hearing? Yes  No   
 If yes, when is your court date? \_\_\_\_\_
5. Has Client been in treatment before for alcohol or drugs? Yes  No   
 If yes, where? \_\_\_\_\_
6. Is the client 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 client allergic to medications, foods, insect stings, plants? YES [ ] NO [ ]

If YES, what is client 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 client? \_\_\_\_\_

10. Is the client pregnant? YES [ ] NO [ ]

If Yes, how many weeks pregnant? \_\_\_\_\_

Who is providing prenatal care for the client? \_\_\_\_\_

11. Is the client physically challenged? (For example, does the client use a wheelchair, crutches, cane or does the client have vision or hearing difficulties?) \_\_\_\_\_

**E. EMOTIONAL/BEHAVIORAL:**

1. Does the client 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 client have a history of fire setting? YES [ ] NO [ ]

If yes, describe: \_\_\_\_\_

3. Does the client have a history of cruelty to animals? YES [ ] NO [ ] Describe: \_\_\_\_\_

\_\_\_\_\_

4. History of bedwetting? YES [ ] NO [ ]

5. Has the client been hospitalized for emotional/mental problems? YES [ ] NO [ ]

Hospital	Location	Dates of treatment	Reason for Admission
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\_\_\_\_\_  
 \_\_\_\_\_

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

7. Does the client have a history of self-injury or suicide attempts? YES  NO

Date: Method Name of Hospital # Days in Hospital Substance Abuse Involved?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Additional information, re: suicide attempts, such as intervention/treatment: \_\_\_\_\_

8. Is the client currently self-harmful or suicidal? YES  NO

If YES, describe: \_\_\_\_\_

9. Does the client have a history of violence: YES  NO  If YES, describe: \_\_\_\_\_

a. History of violence to self or others? (e.g. self-choking, etc.) YES  NO

b. Has client been a victim of violence from others? YES  NO

Describe: \_\_\_\_\_

10. Has the client been involved in a gang? YES  NO  If YES, which gang? \_\_\_\_\_

Gang colors & Attire: \_\_\_\_\_

Describe the client's involvement with the gang: \_\_\_\_\_

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

\_\_\_ **Alcohol** How much and how often: \_\_\_\_\_

\_\_\_ **Sedative Hypnotics/ tranquilizers** (Valium, Librium, Miltown, 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/howoften: \_\_\_\_\_

\_\_\_ **Tobacco:** Smoking [ ] How much/How often: \_\_\_\_\_

Chewing [ ] How much/How often: \_\_\_\_\_

\_\_\_ **Caffeine:** (Coffee, Soda) How much per day? \_\_\_\_\_

\_\_\_ **Inhalants** (Glue sniffing) If yes, how much/how often: \_\_\_\_\_

\_\_\_ **Other Type:** \_\_\_\_\_ How much and How often: \_\_\_\_\_

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

If YES, which substances caused withdrawal or severe hangovers \_\_\_\_\_

Has the client had **Blackouts**? YES [ ] NO [ ] If yes please explain \_\_\_\_\_

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

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

Has the client 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 Client 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 client willing to come to treatment voluntarily? YES [ ] NO [ ]

**H. RECOVERY ENVIRONMENT**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Is there anyone currently living in the client's home who is in poor health? YES [ ] NO [ ]

If YES, describe condition: \_\_\_\_\_

3. Is there anyone currently living in the client's home who is an active substance abuser? YES [ ] NO [ ]

If YES, relationship and substance abused: \_\_\_\_\_

4. Is there anyone currently living in the client's home who is active in a program of recovery? YES [ ] NO [ ]

If YES, relationship and circumstances: \_\_\_\_\_

5. Does the client have access to an Aftercare Program? YES [ ] NO [ ]

If yes, what organization and contact person? \_\_\_\_\_

\_\_\_\_\_

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

Living Situation: \_\_\_\_\_  
\_\_\_\_\_

School Work: \_\_\_\_\_  
\_\_\_\_\_

Aftercare Program: \_\_\_\_\_  
\_\_\_\_\_

7. What is the family expectation of the client? \_\_\_\_\_

8. Family Strengths: \_\_\_\_\_  
\_\_\_\_\_

9. Family Liabilities: \_\_\_\_\_

10. Additional Information: \_\_\_\_\_  
\_\_\_\_\_

11. Diagnoses:  
(Include Substance Abuse and Mental Health problems. Must be completed by credentialed or licensed provider)

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Axis V: GAF \_\_\_\_\_

12. Explain why Outpatient Treatment is not sufficient at this time: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Print Name of Licensed Provider/Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Licensed Provider / Title

\_\_\_\_\_  
Date

Phone: \_\_\_\_\_

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# Nevada Skies Youth Wellness Center

## What to Bring to Treatment Inventory Check List (Females)

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

- 1 Jacket & Sweater for hiking and outdoor activities
- 7 Shirts or T-shirts, white – No tank tops or tube tops (no lettering or pictures and **no Red or Blue**).
- 7 Pair jeans or slacks that fit – Not oversized or too tight.
- 7 Pair shorts when the weather is warm (Spring, Summer, Fall),  
no “Short shorts” and no Cut-offs, Shorts must be no shorter than 4 inches above the knee
- 2 Pair sweat pants
- Athletic shoes: 2 pair only. No clogs or sandals & No Red or Blue.
- Shower shoes: (flip-flops)
- 7 Pair socks
- Swimming suit (1 piece) (No low or high cuts and no red or blue)
- 7 Briefs or panties (no thongs)
- 3 Bras (No underwires - recommend sport bras)
- Pajamas or sleeping attire
- Knee length dresses/skirts/dress shoes

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

- Toothbrush/toothpaste/floss: (No mouthwash containing alcohol)
  - Shampoo and conditioner
  - Deodorant: (non-aerosol)
  - 4 Bars soap: (Ivory or non perfumed hypoallergenic soap)
  - Hand/body lotion
  - Tampons/maxi-pads/panty liners
- Hygiene products will be provided if needed

**DO NOT bring aerosols, cologne, perfume, 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.  
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 (including earrings and watches), pillows, blankets, towels, stuffed animal, sunglasses, food, gum, candy, weapons of any kind, or anything of value. Your money will be kept in a locked safe; you may request your money with approval of the Treatment Team. Alcohol, other drugs and tobacco products are NOT allowed.**

Thank You

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

# Nevada Skies Youth Wellness Center

## What to Bring to Treatment Inventory Check List (Males)

**Clothing: Absolutely NO gang colors or lettering: No alcohol/drug/gambling-related logos or any clothing. Absolutely **NO Red or Blue****

- 1 Jacket & Sweatshirt for hiking and outdoor activities
- 7 Shirts or T-shirts, White. (Plain, no lettering or pictures) (No tank-top T shirts)
- 7 Pair jeans or slacks that fit – Not over sized or too tight.
- 7 Pair shorts when the weather is warm (Spring, Summer, Fall),  
no “Short shorts” and no Cut-offs, Shorts must be **no shorter than 4 inches** above the knee
- 2 Pair sweat pants
- Athletic shoes: 2 pair only & No RED or BLUE
- Shower shoes: (flip-flops)
- 7 Pair 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)
  - 4 Bars Soap: (Ivory or non perfumed hypoallergenic soap)
- 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.  
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 (including earrings and watches), pillows, blankets, towels, stuffed animal, sunglasses, food, gum, candy, weapons of any kind, or anything of value. Your money will be kept in a locked safe; you may request your money with approval of the Treatment Team. Alcohol, other drugs and tobacco products are NOT allowed.**

Thank You

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