DESERT VISIONS YOUTH WELLNESS CENTER

198 South Skill Center Road
P.O. Box 480
Sacaton, AZ 85147

Tel: 888-431-4096
Tel: 520-562-4241

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 520-562-3415 and **call** 520-562-4241 and leave a message stating that a fax was sent
- A phone screen with the client will be performed by a Desert Visions staff as part of the admission process.
- A client will not be admitted to Desert Visions without a legal guardian present at the time of admission.
- Community service may be performed while the client is enrolled in the Desert Visions program.
- A client will only be discharged to a legal guardian.

TREATMENT MODEL AND PHILOSOPHY OF CARE

The purpose of the Desert Visions 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 Desert Visions uses the medical model in viewing alcohol dependence as a disease. Desert Visions 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 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. Desert Visions 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.

Desert Visions Youth Wellness Center

Admission Criteria

Criteria for Admission/Re-Admission to Desert Visions 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. Desert Visions staff will complete telephone screen with applicant and legal guardian prior to application approval.

6. Legal guardian must accompany client to Desert Visions on admission date to check minor into facility.

The following conditions may preclude admission to Desert Visions:

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 – Desert Visions 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**

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

Please fax the following documents to 520-562-3415

Attention: Intake Department

PLEASE PRINT LEGIBLY- USE BLACK INK

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

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:

I. 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:

I. 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:

I. 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 DESERT VISIONS 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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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 (heroine, 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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PATIENT IDENTIFICATION	NAME (First, M.I. Last)	RECORD NUMBER
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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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PATIENT IDENTIFICATION	NAME (First, M.I. Last)	RECORD NUMBER
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Desert Visions 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 weather is warm
No "short shorts" or Cut-offs, Shorts must be no shorter than 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/skrists/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.
Desert Visions 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, **iP**ods/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

Desert Visions 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. Desert Visions 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.

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