



Treatment Directory Information Form
Day Treatment and Intensive Outpatient Programs
Please return completed forms to: treatmentdirectory@joyproject.org
Or mail to: PO Box 16488, St Paul, MN 55116

Name of Treatment Center: _____

Address: _____

State: _____ Zip: _____

Phone Numbers: _____

Fax: _____ E-mail: _____

Website (if available): _____

Name of Program Director: _____

Facility Information

Is the facility: _____ **Partial Hospitalization** _____ **Intensive Outpatient**

**Feel free to fill out a separate form for each level of programming*

Hours of Programming:

Please provide times of arrival, departure, and days attended per week.

Number of Individuals in Program:

Maximum:

Average:

Average Length of Involvement in Program:

Minimum/ Maximum Commitments:

Internal Environment Layout/ Description:

Please describe the internal environment of the treatment facility. Is it located in a house/ hospital, office setting, home, et cetera...

What Licenses does Your Facility Have?

JCAHO

Other

Date Founded/ Years of Operation:

Patient Information

Average Age:

Minimum and Maximum Age:

Are different age groups separated?

Do you accept males for treatment?

Separation of Sexes:

Does this program specialize in any specific population (ie, males, GLBT community, BED?)

Facility Philosophy

Treatment Philosophy:

Please briefly describe the treatment philosophy of the program.

Use of Exercise/ Physical Therapy:

Please describe exercise plans including different types of exercise offered, criteria for participation, and frequency of therapy.

Description of Meal Plan:

Please describe the system used for meal planning and anything unique or different about this programs' meal planning.

Please Describe Your Policy (if any) on Caffeine:

Does the Center Have Any Religious Affiliation?

Please describe the religious activities/ associations of the program and expected client involvement in spiritual activities, and how your facility incorporate spirituality into its programming.

Admissions

Types of Eating Disorders Treated:

Anorexia Bulimia EDNOS Obesity Binge Eating Disorder
 Exercise Disorder Compulsive Overeating
 Other {Night Eating Syndrome, Pica, etc. (Please List)}

Requirements for Admission:

Process:

Please describe the admission process to the program.

Waitlist:

Please describe the admission process when an immediate opening is not available.

Staff

Types of staff who work in your program:

Please provide number of individuals typically on staff as well

- | | | |
|--|---|---|
| <input type="checkbox"/> Physician (MD) | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Ph.D. Therapists |
| <input type="checkbox"/> RD | <input type="checkbox"/> Masters Level Clinical Therapist | <input type="checkbox"/> Psy.D. Therapists |
| <input type="checkbox"/> RN | <input type="checkbox"/> Master's Level Social Worker | <input type="checkbox"/> Holistic Therapy Staff |
| <input type="checkbox"/> Doctoral level researcher | <input type="checkbox"/> BA/BS Level Social Worker | <input type="checkbox"/> Educational/Teacher |
| <input type="checkbox"/> Nutritionist | <input type="checkbox"/> Administrative | <input type="checkbox"/> Interns |
| <input type="checkbox"/> Other Staff (Please list) | <input type="checkbox"/> Other research staff | |

Credentials: Please describe the typical education level of staff providing the following services:

Therapists:

Medical:

Primary Supervision/ general:

Staff to Patient Ratio/ Number of Staff:

Family/Friend Involvement

Please describe the type and expected amount of family involvement:

What role do friends play in the treatment process?

Cost & Financial Information

Average Cost/ Deposit:

Per Day:

Per Week:

Average Cost for Entire Involvement:

Are there any groups that are not typically covered by insurance, i.e. equine therapy, massage?

Financial Services Available:

Please describe any financial services available, including payments plans, if any.

Outcome/ Recovery of Clients

How does your organization track the effectiveness of your programming?

Do you currently conduct outcome studies? Yes No

How long has your organization been conducting outcome/effectiveness studies?

6 months or less 7-11 months 1-2 years 3-5 years
 6-10 years 11+ years N/A

What length of time do your outcome studies measure?

Before treatment During treatment
 1-3 months after 4-6 months after 7-9 months after
 10-12 months after 13-17 months after 1.5 years to 5 years after
 >5 years after N/A

How do you define client recovery?

What factors do you ask about/consider in treatment effectiveness? (please indicate order of importance using numbers—1 for ‘most important’, 2 for ‘second most important’, and so on)

BMI Quality of Life Medical Problems
 Rehospitalization Remittance of Symptoms Psychological Assessment
 Cognitive/Neurological Assessments Other(Please describe)

Treatment Programming:

Please check all treatment modalities that are offered.

- | | |
|---|---|
| <input type="checkbox"/> 12-Step | <input type="checkbox"/> Acupuncture/Acupressure |
| <input type="checkbox"/> Aftercare | <input type="checkbox"/> Art |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Body Image |
| <input type="checkbox"/> CBT | <input type="checkbox"/> Contract |
| <input type="checkbox"/> DBT | <input type="checkbox"/> Dance/Movement Therapy |
| <input type="checkbox"/> Experiential | <input type="checkbox"/> Equine/ Animal |
| <input type="checkbox"/> Family/ Family Systems | <input type="checkbox"/> Food/Feelings |
| <input type="checkbox"/> Goal Setting | <input type="checkbox"/> Intimacy/ Sexuality |
| <input type="checkbox"/> Journaling | <input type="checkbox"/> Light Therapy |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Meditation |
| <input type="checkbox"/> Music | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Physical Therapy/ Exercise | <input type="checkbox"/> Process |
| <input type="checkbox"/> Psychodrama | <input type="checkbox"/> Psychoeducation |
| <input type="checkbox"/> Recreational | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> Spirituality | <input type="checkbox"/> Traditional Group (Talk) Therapy |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Eye Movement Desensitization | <input type="checkbox"/> Financial Planning after discharge |
| <input type="checkbox"/> other (Please Describe): | |

Please make any notes regarding you treatment programming that you find special or unique:

Please describe free/unstructured time in the program

Medical Monitoring

Is medical monitoring available?

If medical monitoring is available, please describe the process of medical monitoring within your program.

Is medical monitoring required?

Are clients required to be weighed?

Individual Therapy

Please describe individual therapy within the program.

How often do clients meet with their individual therapists/dieticians? Are they required to meet with individual therapist/individual dieticians? Do they meet within program time or outside of programming hours?

How are clients matched with individual therapists?

Please describe the ability of the program to address co-existing psychiatric conditions (depression, addictions, self-injury, etc):

Program to Client Fit

Who would your program be ideal for?

Is there any reason that would make a person not a good candidate for your program?

Questions for Centers that are non Eating Disorders Specific

Name of staff members well-trained in eating disorders specific treatment:

Approximately what percentage of the clients treated are eating disorder patients?

Are eating disorder patients fully integrated with other patients, or are the programs separated?

Miscellaneous

Please describe travel/parking at your program facility:

Please include a sample schedule if available.

Please attach any rules/ general policies, including items not allowed.

Is there anything else we have not covered that you would like to add?

Please send or attach any promotional materials, ads, or articles that would be helpful for someone considering your services!

Thank you!