

The Joy Project

* Where Hope Takes Root *



Treatment Directory Information Form Inpatient and Residential 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

Program Type: _____ Inpatient _____ Residential

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

Average Length of Stay:

Number of Individuals in Program:

Maximum:

Average:

Minimum/ Maximum Commitments:

External Environment Description (Urban/Rural):

Internal Environment Layout/ Description:

Please describe the internal environment of the treatment facility. Is it located in a house/ hospital, what is the style of décor (modern, Victorian, country house, etc.)

What Licenses does Your Facility Have?

JCAHO

Other

Date Founded/ Years of Operation:

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 of 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 incorporates 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.

Patient Information

Average Age:

Minimum and Maximum Age:

Are different age groups separated?

Do you accept males for treatment? (Y/N)

Separation of Sexes:

Relapse Rate (if available):

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

Accommodations

Beds:

Please describe the living accommodations, including bathroom/ bathing facilities:

Locked Facility: (Y/N)

Smoking Allowed: (Y/N)

Tube Feeding/ Food Replacement Policies: *Please describe the programs use of non-food nourishment, including tube feeding, supplements, etc. and guidelines regarding use.*

Staff

Types of Staff in your organization:

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 Therapists | <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"/> Educatinal/Teacher |
| <input type="checkbox"/> Other research staff | <input type="checkbox"/> Adminsitrative | <input type="checkbox"/> Interns |
| <input type="checkbox"/> Other Staff (Please list) | | |

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:

Visitation Policies and Family Involvement

Please describe the type and expected amount of family involvement:

Visitation Policy:

Cost

Average Cost/ Deposit:

Per Day:

Per Week:

Average Cost for Entire Stay:

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 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?

- | | | |
|---|---|---|
| <input type="checkbox"/> Before residential | <input type="checkbox"/> During residential | <input type="checkbox"/> Less than 1 year after residential |
| <input type="checkbox"/> 1-3 months after | <input type="checkbox"/> 4-6 months after | <input type="checkbox"/> 7-9 months after |
| <input type="checkbox"/> 10-12 months after | <input type="checkbox"/> 13-17 months after | <input type="checkbox"/> 1.5 years to 5 years after |
| <input type="checkbox"/> >5 years after | <input type="checkbox"/> N/A | |

How do you define client recovery?

What factors do you ask about/consider in treatment effectiveness? (Please rank in order of importance. Use '1' for most important, '2' for second most importance, etc)

- | | | |
|--|--|---|
| <input type="checkbox"/> BMI | <input type="checkbox"/> Quality of Life | <input type="checkbox"/> Medical Problems |
| <input type="checkbox"/> Rehospitalization | <input type="checkbox"/> Remittance of Symptoms | <input type="checkbox"/> Psychological Assessment |
| <input type="checkbox"/> Cognitive/ Neurological Assessments | <input type="checkbox"/> Other (Please describe) | |

Treatment Programming:

- | | |
|---|---|
| <input type="checkbox"/> Traditional Group (Talk) Therapy | <input type="checkbox"/> Art |
| <input type="checkbox"/> 12-Step | <input type="checkbox"/> Recreational |
| <input type="checkbox"/> Process | <input type="checkbox"/> Meditation |
| <input type="checkbox"/> Food/Feelings | <input type="checkbox"/> Experiential |
| <input type="checkbox"/> Spirituality | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Psychoeducation | <input type="checkbox"/> Equine |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Dance |
| <input type="checkbox"/> Goal Setting | <input type="checkbox"/> Music |
| <input type="checkbox"/> Body Image | <input type="checkbox"/> Journaling |
| <input type="checkbox"/> CBT | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Relapse Prevention | <input type="checkbox"/> Financial Planning after discharge |
| <input type="checkbox"/> Family | <input type="checkbox"/> Family Systems |
| <input type="checkbox"/> Intimacy/ Sexuality | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Contract | <input type="checkbox"/> DBT |
| <input type="checkbox"/> Aftercare | <input type="checkbox"/> Other |

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

Please describe individual clients ability to work on school:

Please describe free/unstructured time in the program:

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):

Miscellaneous:

Who would your program be ideal for?

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

Please include a sample schedule if available

Please attach any rules/ general policies, including criteria for discharge

Thank you!