**REDC Membership Application**

**Program Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of CEO/Executive Director \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact E-mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:

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

**What levels of care does your program provide for people with eating disorders? (Select all that apply)**

\_\_Inpatient

\_\_Residential

\_\_Partial Hospitalization/Intensive Day Treatment

\_\_Intensive Outpatient

\_\_Outpatient

**What ages does your program treat? (Select all that apply)**

\_\_Child

\_\_Adolescent

\_\_Adult

What genders does your program treat? **(Select all that apply)**

\_\_Male

\_\_Female

\_\_Non-Binary

\_\_Transgender

What is your total program capacity?

Number of inpatient beds: \_\_\_\_\_

Number of residential beds: \_\_\_\_\_

Number of PHP/IDP spots: \_\_\_\_\_

Number of IOP spots: \_\_\_\_\_

Please list all facility locations and information.

|  |  |  |
| --- | --- | --- |
| **Names of Facilities** | **Address** | **Number of Beds, PHP, and IOP spots** |

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

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

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

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

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

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

*»Please list all facility locations and information. We use the address information for policy-related work so our Policy Team can contact members in specific locations as needed for advocacy efforts.*

As a condition of membership in REDC, an eating disorder treatment program agrees to:

* Conduct medical/nursing, psychological, psychiatric, and nutritional assessments within 72 hours of admission to 24/7 care, within 1 week in PHP and as appropriate in IOP
* Maintain appropriate licensure per applicable law
* Maintain continuous clinical staffing by licensed staff or trainees under the direct supervision of licensed staff
* Provide for a multidisciplinary team treatment approach with psychiatric, psychotherapeutic, nutritional, and medical staff
* Complete a multidisciplinary treatment plan within 1 week of admission
* Provide weekly (at minimum) visits by each member of the treatment team
* For 24/7 programs, ensure supervision of residents 24 hours a day by trained program staff
* For 24/7 programs, ensure nursing services on-site and medical staff accessibility 24/7
* Ensure supervision of all meals and snacks by trained program staff
* Communicate a thorough discharge plan to the individual, family and receiving team upon discharge, after necessary permission to release information is obtained
* Admit only patients the program can adequately treat given psychotherapy, nutrition, medical and nursing resources, as applicable
* Maintain accreditation by The Joint Commission or CARF, meeting or exceeding the eating disorder specific accreditation standards

We, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (program name), agree we meet these membership criteria.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR OFFICE USE ONLY:

Membership category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Board Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_