DIVISION OF CHILD & ADOLESCENT PSYCHIATRY

Residential Treatment Program Referral Guide

Cincinnati Children's
changing the outcome together

www.cincinnatichildrens.org

Program Overview

Cincinnati Children's College Hill Campus

Admission Criteria

- Meets DSM-5 criteria for a diagnosed psychiatric illness
- Pattern of severe impairment due to psychiatric illness
- Ages 8 to 17: males and females
- Demonstrated developmental capabilities to respond to structured behavioral program
- Fire-setting, history of sexual perpetration, pre-meditated or potential violent behaviors and/or substance abuse requires an additional evaluation prior to admission and cannot be the youth's primary reason for referral to Cincinnati Children's, Residential Treatment Program

Our Units

Three units, totaling 30 beds

- Ages 8 to 12, 10 beds, co-ed
- Ages 12 to 17, 10 beds, co-ed
- Ages 12 to 17, 10 beds, co-ed

Average Length of Stay

4 to 6 months

Location

Cincinnati Children's
College Hill Campus (Location P)
5642 Hamilton Avenue
Cincinnati, Ohio 45224

PHONE: 513-636-0800

cincinnatichildrens.org/residential

0918 BRV277910

Program Focus

The Residential Treatment Program helps children and adolescents express their emotions through appropriate communication and behaviors to enable them to make healthy, positive decisions. Treatment is geared toward helping the youth develop self awareness and self-esteem and ultimately increasing their ability to be an active, productive member in their community. The primary treatment modalities utilized by clinicians include Trauma Focused Cognitive Behavior Therapy (TF-CBT) and Dialectical Behavioral Therapy (DBT), an evidence-based treatment therapy focused on Emotional Regulation, Distress Tolerance, and Mindfulness.

Treatment is provided by many different professionals including Board Certified Psychiatrists, Registered Nurses/Licensed Practicing Nurses and Advanced Practice Registered Nurses, Pharmacists, Therapists, Lead Mental Health Specialists, Recreational Therapists and Behavioral Specialists. Many other services and professionals are available for consultation within the Cincinnati Children's located 6.4 miles from the College Hill Campus.

Treatment Components

The Residental Treatment Program at Cincinnati Children's is located at the College Hill Campus. Staff provide many different therapeutic opportunities to residential patients, including:

- Individualized Assessments
- Individual Therapy
- Milieu Therapy
- Expressive Therapy
- Family Therapy
- Issue-focused groups
- Life Skills Training
- Behavior Modification
- Parenting/Support Groups
- Animal Therapy/Equine Therapy
- Recreation Therapy
- Horticulture Therapy
- Cincinnati Public School Education Services
- 24-hour Nursing & Medication Management
- Non-Denominational Spiritual Opportunities
- Progression/Merit System
- Community Reintegration Services

Partners in Care

Proper and timely communication is essential with referring physicians, agencies and families. The psychiatry staff at Cincinnati Children's is committed to the continuum of care each youth receives. Ongoing communication will occur through-out the treatment process and will include frequent verbal and written communication reports.

Outreach, Educational and Support Services

Our outreach and support services include helping families contact available resources for children and adolescents within Cincinnati Children's Hospital Medical Center and throughout the Cincinnati area.

For more information on Cincinnati Children's and community resources, please call **513-636-0820.**

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Checklist for Referrers

Initial Referral Information

- ☐ Referral Application
- ☐ DAF: Current or Past documentation (Diagnostic assessments, Summaries, Treatment Plans)

Health Related Documentation

- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation with IQ
- ☐ Medication History
- ☐ Complete drug/alcohol assessment (within 6 months if youth is using)
- ☐ Discharge Summaries from prior placements/hospitalizations
- ☐ Immunization Record/Vaccine and Health Information
- ☐ Most Recent Physical Exam/Dental Exam
- ☐ History/Evaluation of OT, PT and Speech Therapy

Social Service and Legal Documentation

- ☐ Social History
- ☐ Legal History

Educational Documentation

- ☐ Educational information: current IEP, MFE, 504 Plan, SBH, etc. statement of special educational needs. Must send copy of IEP or 504 Plan
- ☐ The home school district is required for payment of residential educational services. Must send a copy of court order if applicable

Insurance Information

- ☐ Funding source (agency contract, Medicaid, insurance, etc)
- ☐ All insurance/Medicaid information (photocopy of front/back of card)

Licensing and Accreditation

- Ohio Mental Health and Addiction Services, Mental Health Certification
- Ohio Mental Health and Addiction Services, License to Operate a Residential Facility
- The Joint Commission

Behavioral Health Accreditation

- Funding
- Title IV E Federal Participation Certified Agency
- Commercial Insurance
- Medicaid Certified (Pharmacologic Management, Behavioral Therapy, Diagnostic Assessment)

For referral and/or contract questions, please contact:

residential.referrals@cchmc.org

Kurt Schellinger LISW-S
Residential Intake Coordinator
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kurt.schellinger@cchmc.org

Debbie Brown
Financial Service Representative III
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FAX: 513-636-0810
debbie.brown@cchmc.org

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Business Director/Contracts
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Located at:
Cincinnati Children's
College Hill Campus
5642 Hamilton Avenue
Cincinnati, Ohio 45224

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Please send patient referral information to:

Cincinnati Children's College Hill Campus, Attn: Admission Intake Coordinator
5642 Hamilton Avenue, Cincinnati, Ohio 45224 — or Fax it to: 513-636-0810

Referrals:

513-636-0820 or 1-800-304-8761
residential.referrals@cchmc.org

Date:	Previous Referral: Yes or No (circle one)	
PATIENT INFORMATION		
Name (Last, First, MI):		
Social Security #:	DOB:	Male or Female (circle one)
County:		
Address (street, city, state, zip):		
Parent/Guardian Name(s):		
Home Phone: (_____) _____ – _____	Work/Cell: (_____) _____ – _____	
Parent's School District:	Current Grade:	
Current School Placement:	IEP or 504 (circle one)	
School Address & Phone:		
Does child need a Private Room: Yes or No (circle one) If Yes, please explain:		
Patient currently residing: ☐ Inpatient ☐ In Home ☐ Detention Center ☐ Other _____		
FUNDING SOURCE (Please include front and back copy of Insurance or Medicaid card)		
Funding Source (i.e. Insurance / Medicaid card, agency billing information):		
REFERRING AGENCY INFORMATION		
Referring Provider Name :		
Address (street, city, state, zip):		
Work Phone: (_____) _____ – _____	Fax Number: (_____) _____ – _____	
Agencies involved / placement history / medications / any history of legal problems:		
ASSOCIATED DIAGNOSES (Please list all)		
1. Psychiatric	2. Medical	
PRIMARY CONCERN	**EXPECTATIONS OF RESIDENTIAL TREATMENT**	
☐ Mood Disturbance ☐ Anxiety ☐ Depression ☐ Self Harm ☐ Rule Breaking ☐ Truancy ☐ Oppositional Behavior ☐ Impulsivity ☐ Hallucinations ☐ Problematic Relationships ☐ Substance Abuse ☐ Court Involvement		

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