RISE
HEALTHY HOUSING
AND SUPPORT SERVICES

The SunRise Retreat is a voluntary, short-term (28-day max), 12 bed Intensive Crisis Residential treatment service for those experiencing acute crisis or exacerbation of their mental health symptoms. Our goal is to provide a stable and healthy environment, that will assist individuals in their healing process.

At SunRise, the resident can expect.

- A comfortable community-based home like setting with individual rooms.
- Individual / Group Counseling services.
- Access to a medication provider, if necessary.
- 24/7 professional staff

Admission Criteria

The Resident:

- must be 21 years of age or older.
- has a primary psychiatric diagnosis.
- be experiencing an acute psychiatric crisis and/or;
- experiencing challenges in daily life that create risk for an escalation of behavioral health symptoms and a loss of adult role functioning.
- requires treatment services for stabilization of psychiatric symptoms.
- requires 24-hour monitoring.
- be medically stable.
- is willing to participate in service voluntarily.
- agrees to not be under the influence of alcohol or illicit drugs at the time of admission and for the duration of their treatment.
- is willing to agree to program rules and regulations at time of admission.
- is willing to agree to personal item inventory and searches for safety of all residences and staff.

***** Personal Vehicles are not authorized for use or to be on the premises while admitted to SunRISE.**

Please fill out the referral form and attach the requested documentation listed below. This packet can be emailed to Sunriseadmissions@riseservices.org for consideration.

Requested documentation:

- Recent mental health assessments
- Recent admission and/or discharge paperwork from hospitals/mental health inpatient settings.
- Recent lab work
- List of medications and providers.
- Releases (for referral agency and the client's emergency contact)

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REFERRAL FORM

Name	Date
Date of Birth	Contact number

Referring Agency / Agency Contact Name / Phone:

Where does the individual reside?

Insurance: Insurance ID:

Reason for Referral:

Current Mental Health Symptoms:

Primary Psychiatric Diagnosis:

Hospitalization History:

Medical Diagnosis:

Substance Use Diagnosis:

Last use:

Allergies:

History of violence (Domestic or other) and/or aggression (if yes, please explain): ☐ YES ☐ NO

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Primary Care Doctor: (Name of Practice, Provider, Address, Phone number)
Pharmacy: (Name, Address, Phone number)
Therapist: (Name of Practice, Provider, Address, Phone number)
Psychiatric Medication Provider: (Name of Practice, Provider, Address, Phone number)
Case Manager: (Name of Agency, Name of Provider, Address, Phone number, email)
Specialty Doctors: (i.e. Cardiologist, Endocrinologist, Neurologist, etc.) (Name of Practice, Provider, Address, Phone number)
Other agencies involved with the client: (i.e. Addiction Services, Rehabilitation providers, PROS, etc.) (Name of Agency, Provider, Address, Phone number, email)
Upcoming appointments: (Name of agency, date, time)