



## Welcome to SunRISE Retreat

SunRISE Retreat is a voluntary, Short-term intensive crisis residential service designed for individuals aged 21 and older, offering a maximum stay of 28 days. Our goal is to create a stable and healthy environment that supports the healing process during times of acute mental health crisis.

### What Residents Can Expect:

- **Comfortable Setting:** Enjoy a community-based home-like atmosphere with individual rooms.
- **Counseling Services:** Access to both individual and group counseling to aid in recovery.
- **Case Management Services:** Assistance in getting connected to community based resources.
- **Medication Provider:** Available as needed to manage mental health symptoms.
- **24/7 Professional Staff:** Continuous support from dedicated professionals.

### Admission Criteria:

To ensure the safety and appropriate care for all, residents must meet the following criteria:

- Must be 21 years of age or older.
- Have a primary mental health diagnosis and be experiencing an acute psychiatric crisis or challenges that risk escalating mental health symptoms.
- Require treatment services for stabilization and 24-hour monitoring.
- Be medically stable and willing to participate voluntarily.
- Agree to remain alcohol and drug-free and comply with program rules.
- Consent to personal items inventory and searches for safety purposes.

### Referral Process:

**Please complete the referral form in its entirety** and attach the following documentation:

- Recent mental health assessments
- Recent hospital admission/discharge paperwork
- Recent lab work (for medication purposes, if applicable)
- List of medications and providers
- Releases for the referring agency

Submit your referral packet via email to: [Sunriseadmissions@riservices.org](mailto:Sunriseadmissions@riservices.org)

### Please Note:

- Personal Vehicles are not permitted on the premises during your stay unless approved by the program director for employment purposes only.
- New admits are subject to a breathalyzer upon admission and upon suspected use thereafter.



## REFERRAL FORM

Name:

Date:

Social:

Date of Birth:

Gender:

Pronouns:

Insurance:

Insurance ID:

Address:

Phone:

Referral Agency:

Agency Contact / Phone:

Does the individual use any medically assisted devices ( e.g., mobility aids, oxygen tanks, hearing aids, prosthetics, C-PAP, etc.) If yes, please explain:

Reason for Referral:

Current Mental Health symptoms:

Psychiatric Diagnosis:

Hospitalization History:

Substance Use History & Last Use:

History of Violent and/or Aggressive Behavior:

Medical Conditions:

Allergies:



Was a SPOA been completed for the individual?      Yes      No      What County:  
Has any other housing applications been completed for the individual?      Yes      No

**\*\*Please attach SPOA to Referral if one has been completed.**

**Primary Care**

Practice:      Physician:  
Address:      Phone:

**Pharmacy**

Name:      Phone:  
Address:

**Therapist**

Practice:      Clinician:  
Address:      Phone:

**Psychiatric Medication Provider**

Practice:      Provider:  
Address:      Phone:

**Case Management**

Agency:      Case Manager:  
Phone:      Email:

Please list any other agencies involved with the individual (i.e. Addiction Services, PROS, Rehabilitation)

Please list any upcoming appointments (Agency Name, Date, Time, reason)



Please list 3 to 4 treatment goals the individual would like to attain while at SunRISE retreat.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Referral Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**SUNRISE Retreat**  
**57 Kirby Rd. Saratoga Springs, NY 12866**  
**(518) 587-4277 (P) (518) 583-1196**

**CONSENT TO OBTAIN & RELEASE INFORMATION**

Give a copy of the form to the patient: Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

I, \_\_\_\_\_ do hereby consent to and authorize: **SunRISE Retreat of RISE Housing and Support Services** to obtain and release to: \_\_\_\_\_

**Name of person or Facility**

\_\_\_\_\_  
**Address and Phone Number**

The following information:

- Presence in treatment (Including admission and discharge dates)
- Diagnosis, brief description of progress and prognosis
- Medical History and physical
- Intake assessment
- Psychosocial assessment
- Treatment Plan (problems, strengths, Identification, goals) Discharge Summary
- Aftercare Plan
- Other: \_\_\_\_\_

This information is needed for the following purposes:

- To complete an alcohol evaluation
- To provide ongoing communication with referring agency
- To provide ongoing treatment/aftercare
- To obtain insurance, employment or government benefits
- To enable judges, attorneys, probation/parole officers to support treatment goals
- To coordinate treatment efforts with family/concerned persons
- To coordinate treatment and aftercare efforts with employers
- Other: \_\_\_\_\_

I, the undersigned have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such Information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. The consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 & 164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: One Year from Date of Signing

Note: Any information released through this form will be accompanied by the form prohibition on Redisclosure of the Information Concerning Alcoholism /Drug Abuse Patient (TR-1 A-4400)

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

NOTE: You must also initial the Individual Authorization sheet in your chart.